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THE AMERICAN JOURNAL OF PSYCHIATRY

11

In this issue

John G. Gunderson and Margaret T. Singer on Defining Borderline Patients

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Final classification of the less-than-effective indications requires further investigation.

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Indications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil, brand of imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

—patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;

—patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;

—hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;

—patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;

—patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, Tofranil, brand of imipramine hydrochloride, is not recommended for treatment of depression in patients under twelve years of age.

Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil, brand of imipramine hydrochloride, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil, brand of imipramine hydrochloride, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. Dosage should be initiated with Tofranil, brand of imipramine hydrochloride, at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission.

Once-a-day maintenance dosage can be provided with Tofranil-PM, brand of imipramine pamoate, capsules if this dosage has been established as explained above. This dose may be given at bedtime. For the occasional patient who manifests stimulation and insomnia with this dosage regimen, the capsules may be given in the morning.

Parenteral administration should be used only for starting therapy in patients unable or unwilling to use oral medication. The oral form should supplant the injectable as soon as possible.

How Supplied: Tofranil, brand of imipramine hydrochloride: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg.; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-850-P (2/74)

For complete details, including dosage and administration, please refer to the full prescribing information.

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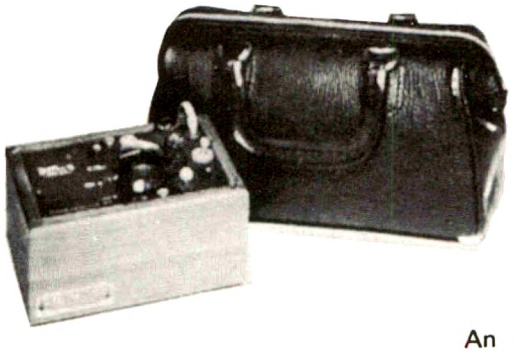
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ELAVIL®
(AMITRIPTYLINE HCl|MSD)
useful in many therapeutic settings



In the psychiatrist's office. Whatever other therapeutic facilities have been developed, the psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations.

In the general hospital. The general hospital today usually provides a psychiatric unit where depressed patients may be treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic. With follow-up treatment often necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital. Here where severely depressed patients present challenges for psychiatrist and staff alike, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



In the community mental health center. A remarkable innovation in the field of modern psychiatry, this center offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

In many therapeutic settings—one proven antidepressant

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

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addendum

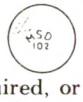
ELAVIL®
(AMITRIPTYLINE HCl | MSD)
dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

in the treatment of clinically significant depression

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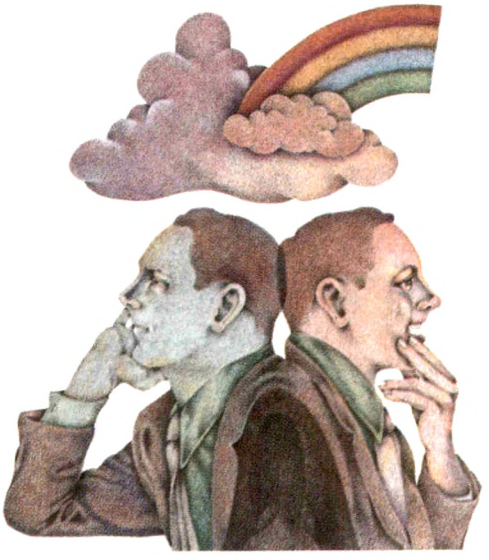
How individual patient variables influence

It is now well established that certain nondrug factors can affect response to antianxiety medication. Thus, even with agents of proven efficacy, such as Librium (chlordiazepoxide HCl), different patients may exhibit varying degrees of symptomatic relief from excessive anxiety and tension.

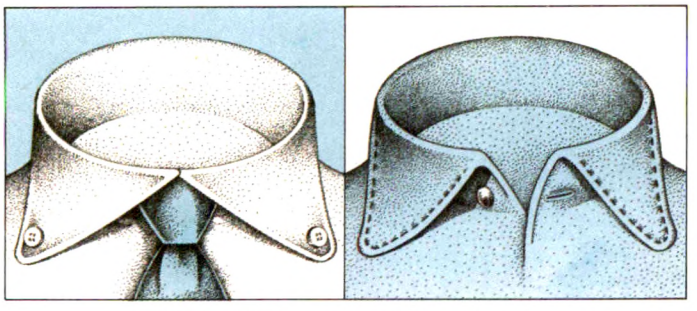
Apart from the effect of the physician's personality and prescribing attitudes on patient response,[1] there are certain significant patient variables, *e.g.*, personality type, severity and duration of anxiety, socioeconomic status, attitude toward medication and insight into the nature of the condition under treatment.[2-4] Thus, some clinical experience suggests that physically active extroverts, for whom abatement of anxiety may decrease the will to achieve or take action, may respond negatively – resulting in exacerbation of anxiety.[2] On the other hand, more passively anxious individuals with intellectual and esthetic inclinations have been shown to benefit from antianxiety medications.

When medication is indicated in the latter group, many psychiatrists place a high value on the benzodiazepines – of which Librium (chlordiazepoxide HCl) was the first in clinical use – for their antianxiety effectiveness, broad usefulness and wide margin of safety.[2,3]

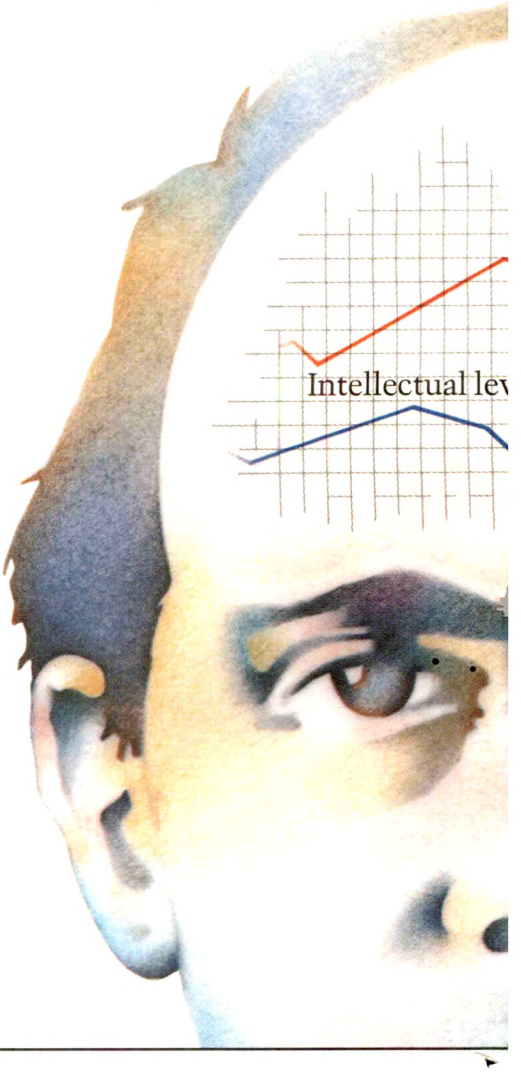
1. Rickels K, Lipman RS, Park LC, Covi L, Uhlenhuth EH, Mock JE: *Psychopharmacologia 20*:128-152, 1971
2. Hollister LE: *Ann Intern Med* 79:88-98, July 1973
3. Greenblatt DJ, Shader RI: *Ibid.*, 77: 91-100, July 1972
4. Rickels K, Downing RW, Howard K: *Clin Pharmacol Ther 12*:263-273, Mar-Apr 1971



Attitude to medication



Socioeconomic status



the effectiveness of antianxiety therapy

Demonstrated predictors of favorable response to Librium (chlordiazepoxide HCl)

In a double-blind, controlled study[4] of psychoneurotic patients with moderately severe anxiety, 111 patients were treated with Librium in a daily dosage of 30 to 40 mg, and 201 patients received a placebo. Outcome criteria included a global improvement measure after 2 and 4 weeks and the 4-week change score of a 10-item physician questionnaire.

Statistical analysis revealed that the greatest drug-placebo difference in relieving anxiety occurred among patients who were more severely ill, those in a higher socioeconomic class and those whose illness had persisted for at least six months. The more educated patient with high verbal ability, greater insight and an accepting attitude toward combined psychotherapy and drug therapy responded *significantly better* to Librium than to the placebo. On the other hand, patients of lower socioeconomic status, with less insight and greater readiness to accept medication alone as sufficient therapy, tend to show a moderately favorable response to both drug *and* placebo.

For proven effectiveness against excessive, obstructive anxiety

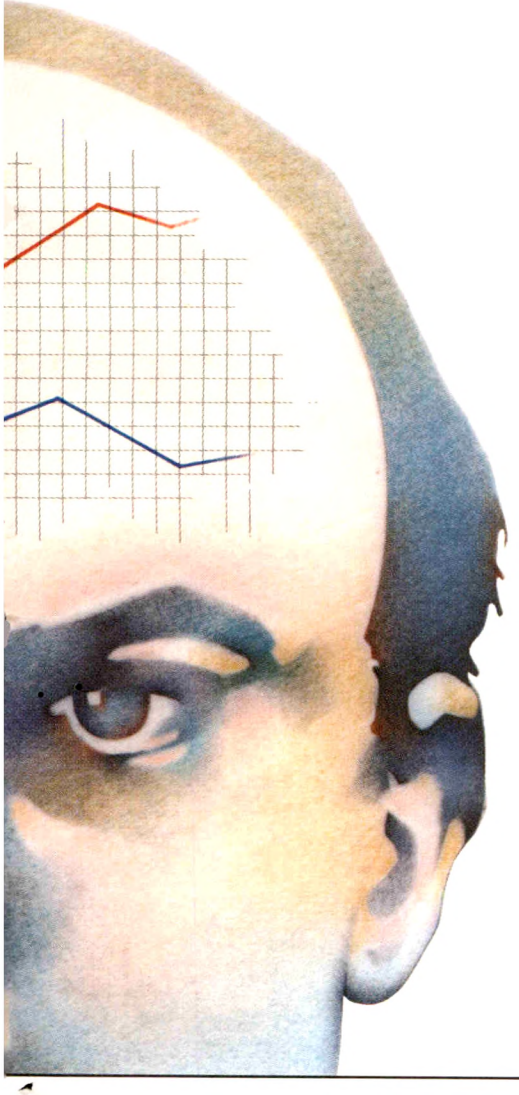
adjunctive

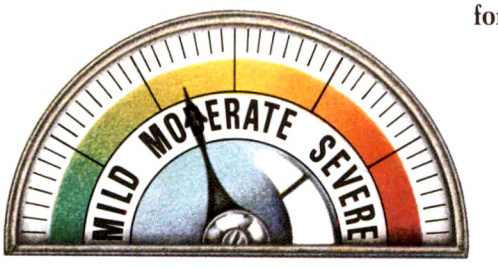
ROCHE **Librium®**

(chlordiazepoxide HCl)

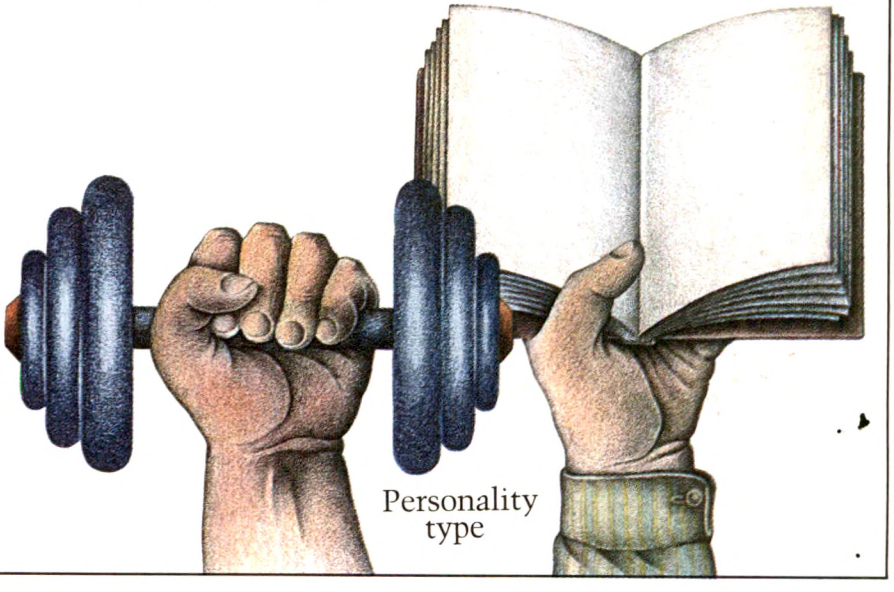
10 mg, 25 mg capsules

Please see following page for summary of product information.





Degree of anxiety



Personality type

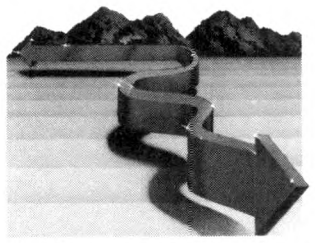
Effective adjunct in psychotherapy

Librium® (chlordiazepoxide HCl)

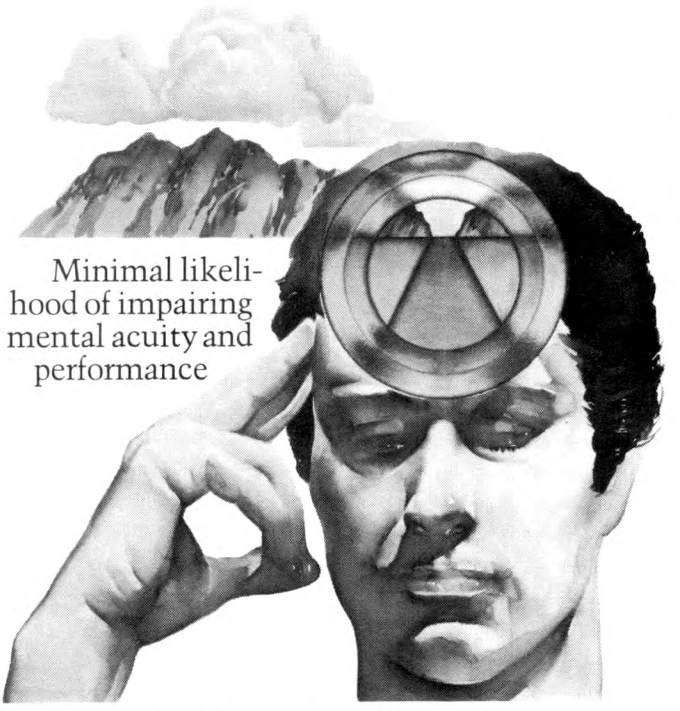
10 mg, 25 mg capsules/up to 100 mg daily in severe anxiety

While drowsiness, ataxia and confusion are the most frequently occurring side effects, physicians should be aware of the possibility of more serious reactions. Before prescribing, please consult complete product information, a summary of which appears below.

When anxiety has been reduced to useful, appropriate levels, Librium should be discontinued.



Wide margin of safety



Minimal likelihood of impairing mental acuity and performance

Dependable antianxiety action

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral– Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

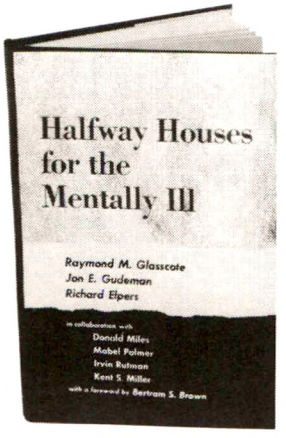
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Four books that came before their time . . .

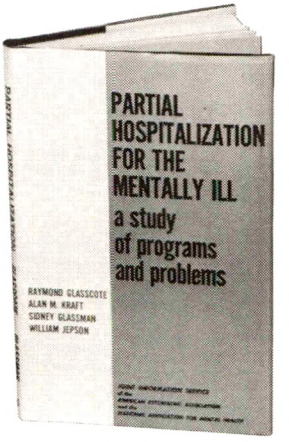
The APA JOINT INFORMATION SERVICE, trying alway to anticipate future needs and trends, expertly carries out field studies to develop information for program planning, for training—and for the practitioner who wants to be fully informed. The JIS saw years ago what most communities and community mental health programs are only now coming face to face with—that vast numbers of the mentally ill will need residential, vocational, and myriad other support services in the community as they are increasingly turned away from state hospitals and back to the cities and towns. Four publications assessing those needs, describing successful pioneering efforts, and providing practical hard-as-nails advice have been issued in the recent past. Unfortunately they are every bit as timely today as they were when they came off the press.

You need to know what they have to say. So we'll meet you part way: list price separately, $24; combination price, $18.50.



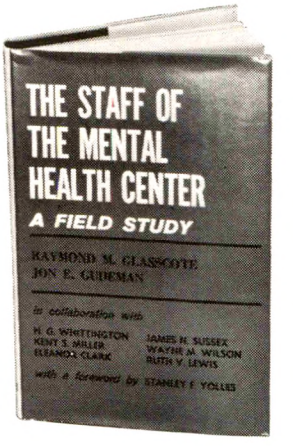
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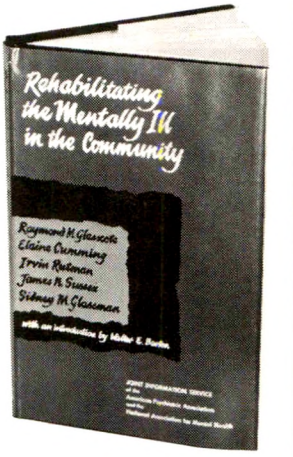
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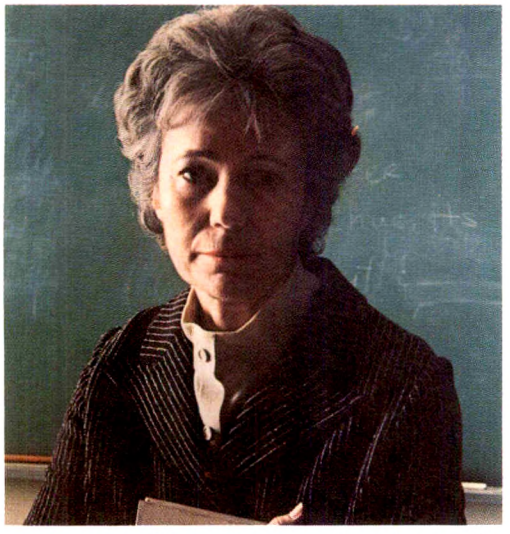
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In the treatment of middle-age depression, there may be one thing to add...



Although the causes of depression in middle-aged women are varied, estrogen depletion is believed by many to be a significant contributing factor in depressions arising in the menopausal years.[1-7]

In the absence of a history of overt psychosis, estrogen replacement therapy alone, or in conjunction with antidepressants and counseling, may provide physiological and, in turn, psychological effect to enhance the total therapy.[7] Estrogen replacement has been noted to relieve the symptoms of estrogen-related depression in a relatively short time.[8] When used with antidepressants, estrogens may help bring about a generalized emotional improvement in patients, while waiting for initial response to slower acting antidepressants.

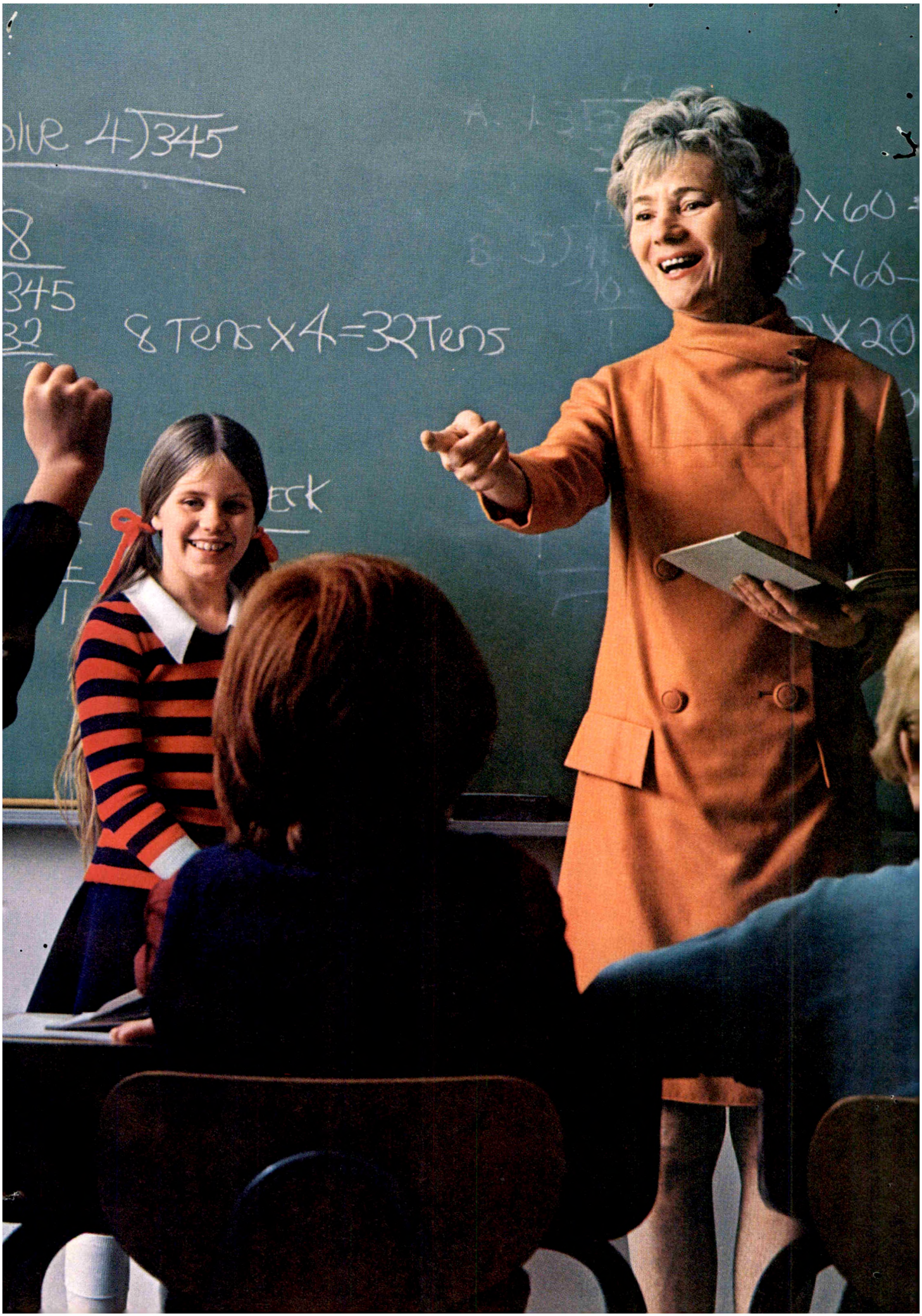
In many estrogen deficient patients, PREMARIN® (Conjugated Estrogens Tablets, U.S.P.) imparts a renewed sense of well-being. It helps alleviate depressive symptoms related to menopausal estrogen deficiency, while helping to identify those that aren't.

Crying spells, insomnia, fatigue, headache, feelings of weakness and other such symptoms may be relieved by estrogen replacement.[6,7] At the same time, the classic autonomic and metabolic symptoms of the climacteric may be controlled.[9,10]

PREMARIN® CONTAINS NATURAL ESTROGENS EXCLUSIVELY
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

for estrogen-related depression

See last page of advertisement for prescribing information.


8 Tens x 4 = 32 Tens

PREMARIN®

BRAND OF

CONJUGATED ESTROGENS TABLETS, U.S.P.

for estrogen-related depression

contains natural estrogens exclusively



BRIEF SUMMARY (For full prescribing information, see package circular.)

PREMARIN® (CONJUGATED ESTROGENS TABLETS, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications for use as follows:

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.

"**Probably**" **effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period — withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome — 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause — as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae) — 0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression) — usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus — 0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865 — Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000. No. 866 — Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 867 — Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. No. 868 — Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

References: 1. Kaufman, S.A.: Obstet. Gynecol. 30:399 (Sept.) 1967. 2. McEwen, D.C.: Can. Nurse 63:34 (Feb.) 1967. 3. Kaufman, S.A., in Olds, S.: Today's Health 48:48 (May) 1970. 4. Klaiber, E.L., *et al.*: Am. J. Psychiatry 128:1492 (June) 1972. 5. Rhoades, F.P.: Mich. Med. 64:410 (June) 1965. 6. Rhoades, F.P.: J. Am. Geriatr. Soc. 15:346 (Apr.) 1967. 7. Kerr, M.D.: Mod. Treat. 5:587 (May) 1968. 8. Tramont, C.B.: Geriatrics 21:212 (Nov.) 1966. 9. Kupperman, H.S.: Med. Aspects Hum. Sexuality 1:64 (Sept.) 1967. 10. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, chap. 69, p. 1538 ff.

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FIRST INTERNATIONAL SYMPOSIUM AND WORKSHOP On: SHORT-TERM DYNAMIC PSYCHOTHERAPY

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Audiovisual facilities are used throughout the four-day symposium and workshops. The aim is to demonstrate by use of videotapes the evaluation, criteria for selection of patients, techniques, process, and outcome of short-term dynamic psychotherapy.

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QUESTION:

WHAT TRICYCLIC ANTIDEPRESSANT IS AVAILABLE AS AN ORAL CONCENTRATE?

A ANSWER: SINEQUAN® DOXEPIN HCl ORAL CONCENTRATE

10 mg./ml., 120-ml. (4-oz.) bottles



- ☐ Effective in the treatment of clinical depression/anxiety
- ☐ Eliminates potential for "cheeking" medication
- ☐ Colorless, tasteless following dilution
- ☐ Contains no alcohol or sugar
- ☐ Easily mixed with water or juices

BRIEF SUMMARY

Sinequan® (doxepin HCl) **Capsules/Oral Concentrate**

Contraindications. Contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* This drug has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: Usage in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's). Sinequan (doxepin HCl) 25 mg. and 50 mg. also available in bottles of 5000. Sinequan Oral Concentrate (10 mg./ml.) is available in 120 ml. bottles with an accompanying dropper calibrated at 5 mg., 10 mg., 15 mg., 20 mg., and 25 mg.

More detailed professional information available on request.

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A brief reminder...



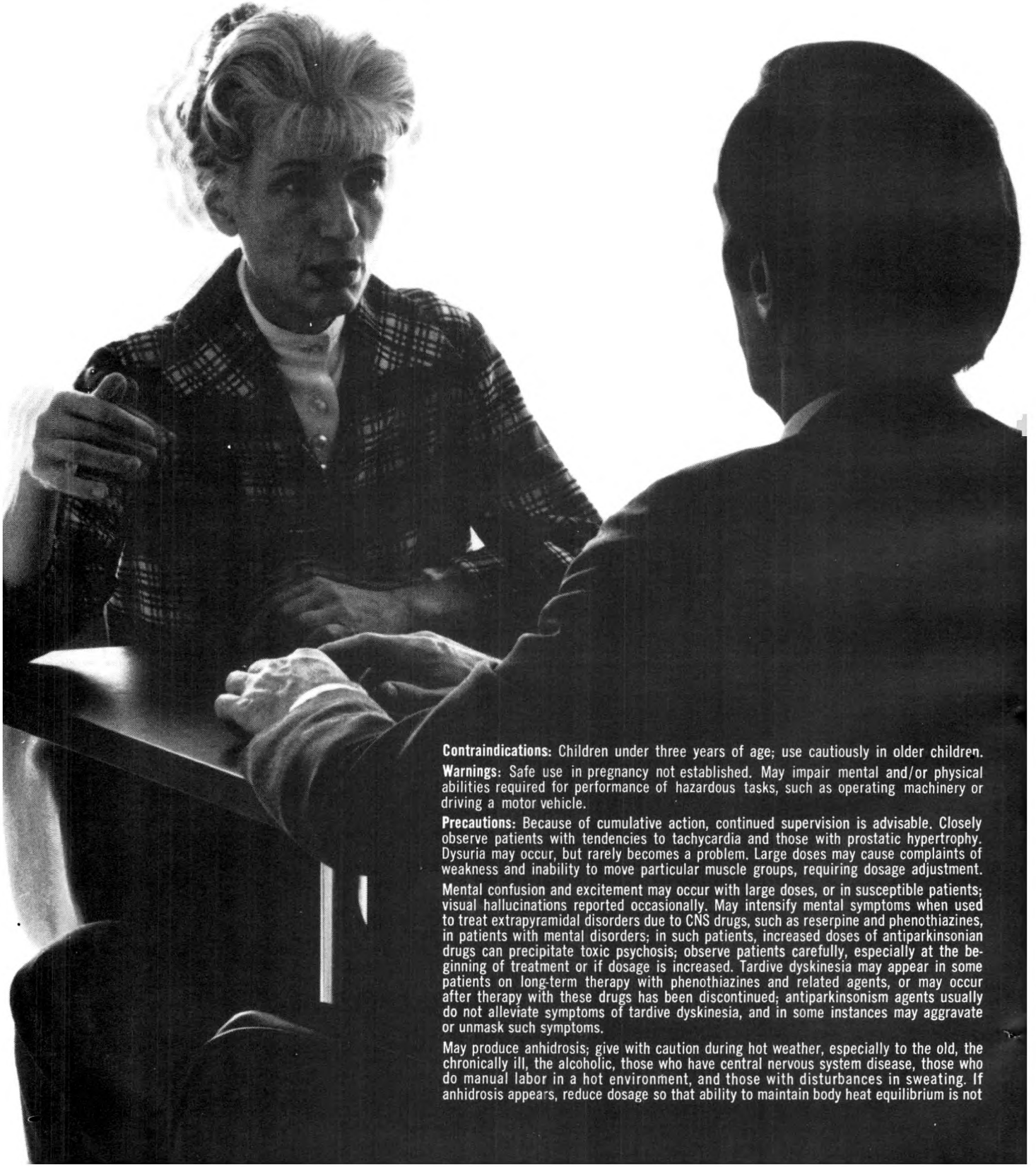
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Six dosage forms and strengths
Tablets: 1, 2, 5 and 10 mg.
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Single Unit Packages: 1, 2, 5 and 10 mg. tablets

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630.
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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)
helps alleviate most phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; Injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

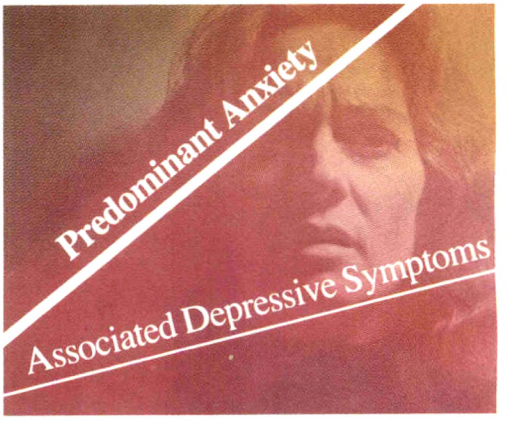
In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to COGENTIN.

For more detailed information, see full prescribing information.

Neither separate nor equal.



Predominant anxiety is often associated with secondary depressive symptoms in a psychoneurotic complex that is important to recognize.

The psychoneurotic patient whose principal symptom is anxiety may also display secondary depressive symptoms. These depressive symptoms are not separate entities but, rather, part of a psychoneurotic symptom complex. As the anxiety responds to treatment with Valium® (diazepam), the depressive symptoms referable to it are also often improved.

The beneficial effect of Valium (diazepam) is usually pronounced and rapid. Improvement is generally apparent within a few days, although some patients may require a longer period. In addition, Valium is generally well tolerated but patients should be cautioned against hazardous occupations requiring complete mental alertness when taking this agent.

When the patient's anxiety and associated or accompanying depressive symptoms are intensified at bedtime, an *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can often relieve the symptoms and thus may encourage a more restful night's sleep.

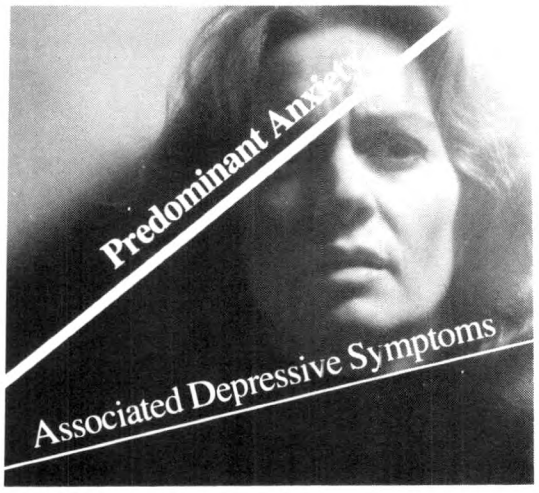


For predominant psychoneurotic anxiety with associated depressive symptoms.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

Please turn page for a summary of complete product information.



For predominant psychoneurotic anxiety with associated depressive symptoms.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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THE NATION'S PSYCHIATRISTS— 1970 SURVEY

prepared by

Franklyn N. Arnhoff, Ph.D.

and

A. H. Kumbar

In this report, the survey data are organized under five general categories.

1. **Supply Characteristics** describes the survey sample in terms of its total number and the percent of response, APA members as well as the number who were in training and those psychiatrists with less than three years' training. It gives data on their age, sex, citizenship, race and work status.
2. **The Education and Training of Psychiatrists** provides data on the number in the sample who graduated from various medical schools by year, the number of years in training, whether the respondent is board certified, etc. All data are analyzed by sex so that this important dimension can be evaluated directly. Data on country of origin of medical school attended are also given for foreign medical graduates.
3. **Professional Activities of Psychiatrists** presents analyses dealing with various aspects of professional practice: where psychiatrists spend their time, how time is allocated, and what they do.
4. **Geographic Distribution of Psychiatrists** presents state totals for the identified manpower pool, along with ratios per 100,000 population.
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Adapting to age:

time and the mind

Aging successfully: is the goal just survival?

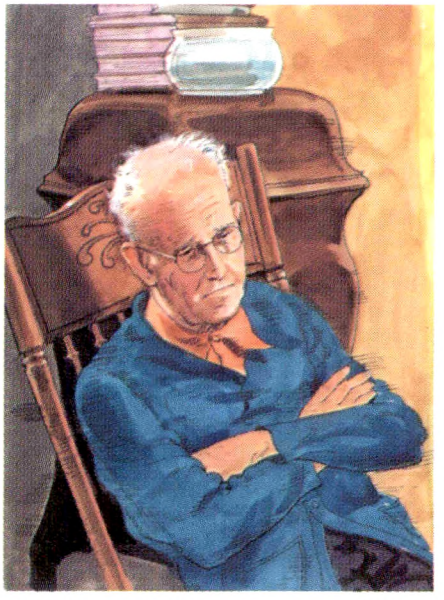
Popular belief would have it that "aging" and "existing" are the same, both marked by deteriorated ability—physical and mental. But is successful aging just existing?

Or is it making the most of one's abilities?

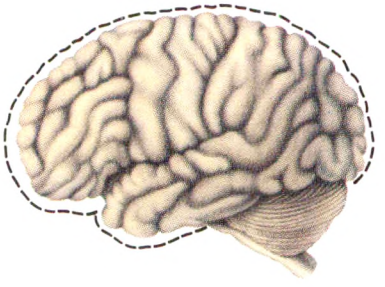
More than just surviving the changes and obstacles of old age, successful aging is *adapting* to the changes and *overcoming* the obstacles. Consider the very fortunate aging individuals who continue active, productive, even socially significant lives. Picasso, painting and sculpting until his death at the age of 91. Stokowski still conducting at 92. Margaret Mead, an active author and anthropologist at 73. Consider, too, those who lack prominence and popular acclaim, but still lead personally satisfying lives. Thus adding meaning to their prolonged existence by following interests and abilities.

How then, can some age so successfully, others less so, and still others merely survive? One reason: individual differences. Not only in abilities, but in opportunities and situations that can either nurture or suffocate ability.

Aging doesn't have to mean ailing bodies and failing minds. True, the cell loss of old age extends to the brain. But







the loss of brain cells doesn't invariably lead to loss of intelligence and alertness. For,

Although the decrease in brain volume is well known, enormous reserves of cerebral cells help compensate for loss with age. Disease and injury, more than advancing age, actually lessen cerebral capacity.

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But we still see senility and seeming mental decline, sometimes caused by





injury to the brain from accident or a disease like cerebral arteriosclerosis. In some cases, the reason may be personality frustration even more than actual brain deterioration: a decline in *performance* generated by severe stress more than a decline in *cognitive ability.* Clinically significant anxiety, alone or associated with underlying organic disease, is common in the elderly, and can cripple the aged mind, and interfere with the adaptive process. But

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*See package circular for full prescribing information.

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Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Not indicated in children under 6 years; absolute dosage for 6- to 12-year olds not established.

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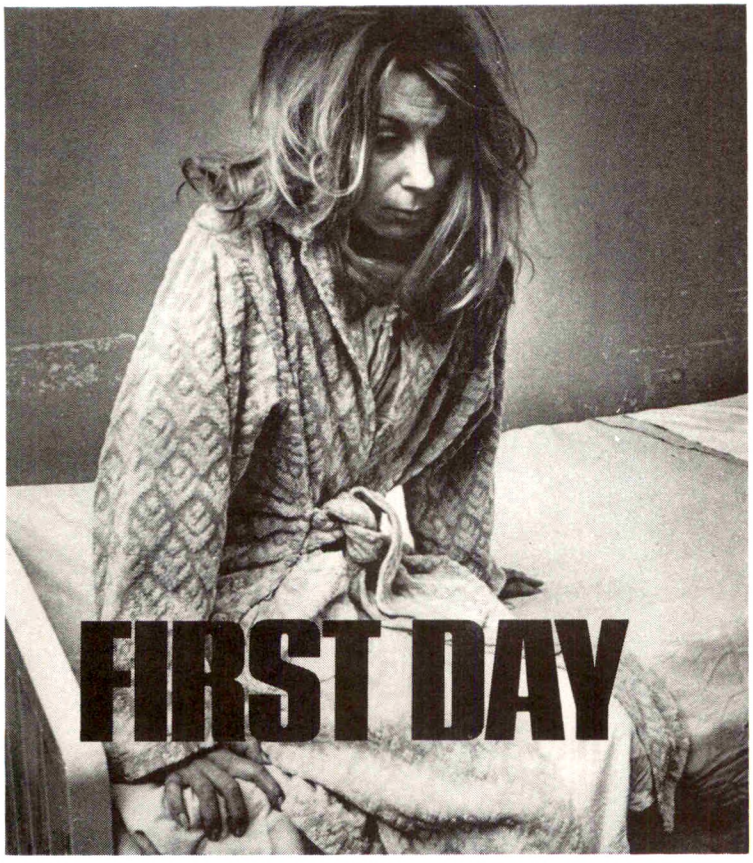
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Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

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THE AMERICAN JOURNAL OF PSYCHIATRY

Defining Borderline Patients: An Overview

BY JOHN G. GUNDERSON, M.D., AND MARGARET T. SINGER, PH.D.

This review of the descriptive literature on borderline patients indicates that accounts of such patients vary depending upon who is describing them, in what context, how the samples are selected, and what data are collected. The authors identify six features that provide a rational means for diagnosing borderline patients during an initial interview: the presence of intense affect, usually depressive or hostile; a history of impulsive behavior; a certain social adaptiveness; brief psychotic experiences; loose thinking in unstructured situations; and relationships that vacillate between transient superficiality and intense dependency. Reliable identification of these patients will permit better treatment planning and clinical research.

IN 1953 KNIGHT NOTED that the term "borderline" was applied to patients who could not be classified in other ways, i.e., as psychotic or neurotic, hence making it something of a wastebasket diagnosis (1). No doubt much of the dissatisfaction with recognizing such a category, whether it is termed borderline or any of its alternative labels, stems from the wish to keep schizophrenia as a clearly distinct disorder. Yet despite this objection, its use has steadily expanded.

Stern (2) was the first to use the term borderline, but the real parentage for this unwanted category is traceable to the "as-if" personality described by Deutsch (3), the ambulatory schizophrenia of Zilboorg (4), and the latent schizophrenia as introduced and developed by Rorschach (5), Bleuler (6), and Federn (7). Latent schizophrenia was sanctioned by Bleuler in 1911 to classify persons whose conventional social behavior he felt concealed underlying schizophrenia. Ambulatory schizophrenia was subsequently offered by Zilboorg in 1941 to combat the therapeutic nihilism that clinicians felt the latent schizophrenia label implied. Deutsch's article on the "as-if" personality described persons whose superficial social appropriateness masqueraded highly disturbed personal relationships.

Before and even after Knight's paper popularized the term borderline, many other names were suggested and then silently retired in favor of the ever-widening use of this term. Among these are preschizophrenia (8), schizophrenic character (9), abortive schizophrenia (10), pseudopsychopathic schizophrenia (11), psychotic character (12), subclinical schizophrenia (13), borderland (14, 15), and occult schizophrenia (16).

The most serious competition in the nomenclature has come from the term pseudoneurotic schizophrenia. This term was particularly popular in New York because of the local influence of its originators, Hoch and Polatin and associates (17, 18). Hoch urged replacing the term borderline with pseudoneurotic schizophrenia, which defined a specific psychopathological condition characterized by the combination of panneurosis, pananxiety, and pansexuality together with symptoms of schizophrenia. The broadening of the concept of schizophrenia which followed in New York may be responsible for a discrepancy in diagnostic habits between New Yorkers and other American psychiatrists as well as the British (19). Yet this term, too, has given way in the most recent APA diagnostic manual (20).

Although the use of the term borderline has become more common, disagreement over its definition has not subsided but has merely been displaced and camouflaged. Many who accept this term now disagree about whether it refers to borderline patient (21), state (22), personality organization (23, 24), character (25), pattern (26), schizophrenia (27, 28), condition (29), or syndrome (30). The increasing frequency of "borderline" patients (31–36), the greatly expanding literature, and the existing confusion about diagnosis and treatment make it imperative that some method for defining the patient group be devised that is replicable and from which research can pro-

Based on papers presented by Dr. Gunderson and Dr. Singer at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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ceed and conclusions can be generalized. In this paper we will attempt to survey the major relevant descriptive accounts of the borderline and to chronicle the common and discriminating features of these accounts.

Before we expand on these descriptive accounts, certain features about the literature itself should be noted. Since Knight's pivotal article appeared, there has been a large and still expanding descriptive literature on the borderline patient. There were approximately 25 articles on borderline patients up to 1955, and that number has doubled in the past 10 years. Nevertheless, there remains a confusing overlap and discrepancy among authors in their descriptive attempts to define borderline patients. While most authors pay lip service to the previous literature, they proceed to describe borderline patients anew without noting how their descriptions add to or simply repeat earlier contributions. It is not clear whether this provincialism stems from an unfamiliarity or an unspoken dissatisfaction with the existing literature.

In this article we will discuss the major descriptive accounts of the borderline syndrome. Clearly, not all of the writings are of equal importance. The work of some authors is extremely well known and widely quoted, while others' work is obscure and/or limited to a single publication. Certain writers attribute every imaginable trait to borderline patients, while others are quite selective in their descriptions. Furthermore, some authors expand or contract their definitions of borderline patients in later publications. In addition, some descriptive accounts are secondary or preliminary to a discussion of other issues, e.g., psychodynamics (37, 38), theory (27, 38), treatment (21, 31–33, 36, 37, 39–42), testing technique (43, 44), and schizophrenia (45). Yet in many the descriptive accounts are the primary goal of the paper (12, 17, 23, 29, 30, 46–49). Among the latter, only Grinker and associates (30) have undertaken a prospective and systematic collection of observations and data analysis.

Nevertheless, each of the authors cited has attempted to articulate his conceptualization of borderline patients and in so doing has implied either his agreement or disagreement with others. Taken in their entirety, these various views reflect the present clinical opinion about these patients. Any attempt by researchers to reliably define borderline patients should encompass these major clinical impressions. In this review, the most common and distinguishing characteristics will be identified, and a rational guide for standardizing clinical criteria for diagnosing borderline patients will be offered.

METHODOLOGICAL PROBLEMS

There are essentially three types of descriptive accounts: symptomatic and behavioral observations, psychodynamic formulations, and psychological test findings. Although these sources of descriptive data are parallel, they seldom seem touched or influenced by each other's proximity. This independence, or ignoring of other sources, arises in part from the different contexts in which the observations are made and reported. Symptom and behavior observations tend to be published in the psychiatric literature and are the purview of clinical researchers and of those involved in residential treatment. Psychodynamic formulations frequent the psychoanalytic literature and usually are developed within individual psychotherapeutic office practice. Finally, the psychological literature contains the accounts made of the borderline patient by psychologists who have administered controlled clinical testing procedures. In addition, the independence of these three groups no doubt grows out of a traditional suspicion each group holds for each other's methodologies. In any event, the psychologist tends to focus upon intrapsychic structure, the psychoanalyst upon theory and therapy, and the general psychiatrist upon diagnosis, prognosis, and outcome.

Clearly, the amount of structure provided by a setting in which the borderline phenomenology is observed will influence how these patients are described. For example, clinicians using psychoanalytic techniques and psychologists using the Rorschach test agree in emphasizing the major ego defects and primitive intrapsychic mechanisms and thinking found in these patients. Yet clinicians observing these patients in structured hospital settings or evaluating them with structured interview techniques emphasize their stable personality features and interpersonal patterns. Certainly the broad agreement among authors from all persuasions (4, 21, 22, 27, 29, 31–33, 35, 37, 39–41, 43, 50, 51) about the borderline patient's proclivity for regression in unstructured settings draws attention to the critical need to define the context in which the observations and descriptions of the borderline patient are being made. This propensity to regress when structure is low becomes an important and perhaps pathognomonic criterion for defining any sample of borderline persons.

The circumstances that lead the borderline person and his evaluator to meet are also important. For example, there appears to be a remarkable contrast between borderline outpatients voluntarily seeking treatment and borderline inpatients, who may be referred by others for treatment. A comparison of the observations made by Hoch and Cattell (17) with those made by Grinker and associates (30), the only authors whose descriptive data were collected in a systematic manner, sheds light on the influence of sample selection upon the conclusions reached about borderline patients.

Both research groups viewed schizophrenia as a distinct pathological condition and selected borderline patients who were free of overt schizophrenic symptomatology, such as clear-cut delusions and hallucinations, on the basis of their history and mental status examination. Hoch and Cattell further limited their sample to patients who presented mainly severe psychoneurotic symptoms, but who, on closer evaluation in psychoanalytic therapy and eventually in hospitals, revealed primary signs of schizophrenia in their thinking, feelings, and physiological functioning. Grinker and associates, on the other hand, selected patients on the basis of good functioning between hospitalizations and the presence of an ego-alien quality to any psychotic behavior. The diag-

nosis of borderline was made on outpatients, who were then hospitalized for participation in a prospective study. Thus Grinker and associates chose as their sample subjects with good premorbid features, and hospitalization was not a clinical necessity but rather for research purposes. It is not surprising, then, that their sample showed rare psychotic phenomena and developed virtually no schizophrenia during a five-year follow-up (52). In contrast, slightly more than one-fourth of Hoch and Cattell's hospitalized population later developed manifest schizophrenia (53).

It is clear that the initial selection of samples influenced the conclusion that Grinker and associates reached that borderlines and schizophrenics have separate and distinct disorders while Hoch and Cattell concluded that their patients were a subgoup of schizophrenics. It is somewhat like packing a suitcase and then being surprised later to find what is in it when it is opened.[1] Most authors choose to regard borderline patients as a group somewhere between, and perhaps including, both of these extremes. Thus the need for hospitalization is a critical variable in comparing samples. Borderline patients who are referred for hospitalization because of severe symptoms would be expected to be more disordered than those functioning as outpatients.

In summary, we have cited four major variables to be considered in any descriptive account of borderline patients: who is describing them, the methods used to collect descriptive data, the context in which the patients were observed, and how the sample was selected. Each has an important impact on the resulting description of borderline patients.

What follows is a selective review of the literature covering three major descriptive conceptualizations of the borderline: first, the literature on symptoms and behavior; second, the psychological test literature; and third, the analytic literature as it views ego functioning.

SYMPTOMS AND BEHAVIOR

In the descriptive behavioral and symptom literature for borderlines, a number of characteristics are repeatedly mentioned that can be grouped under the general headings of affect, behavior, and psychosis. Among the studies that have considered the behavior and symptoms of borderlines, the study by Grinker and associates (30) deserves special citation as the only prospective, systematic one. Despite the slanted selection of patients in that sample, the findings must be considered as the marker against which all other reports should be measured. It is thus of special value to compare the findings of Grinker and associates with those other descriptions based on purely clinical impressions.

[1]Grinker and associates noted that Hoch and Cattell tended to include more clearly schizophrenic symptoms in their later definitions of pseudoneurotic patients. Dyrud (32) has commented that Grinker and associates may have too readily dismissed the relationship between borderline and schizophrenic patients.

Affect

Of the four prevailing characteristics that Grinker and associates found in their borderline patients, two were qualities of affect.

1. *Anger.* "Expressed more or less directly to a variety of targets, anger seems to constitute the main or only affect that the borderline patient experiences" (30, p. 90). The expression of this anger—or the defenses against it—are a major discriminating feature used to identify four separate subgroups of borderline patients.

2. *Depression.* "Not the typical guilt-laden, self-accusatory, remorseful 'end-of-the-rope' type, but more a loneliness as the subjects realize their predicament of being unable to commit themselves in a world of transacting individuals" (30, p. 91). Grinker and associates pointed out that this depression was not present in their healthiest borderline group, which suffered instead from a clinging, childlike, anaclitic depression.

These conclusions by Grinker and associates are given substantial albeit inconsistent support by others. Some authors have noted the prevalence of anger but do not mention depression (21, 33), and vice versa (17, 36, 54). It seems likely that the confusion over the qualities of affect is traceable to at least two major sources. First, there is confusion about whether one is describing affects the patient presents with, affects that are covert, or affects that emerge in treatment. Second, as some authors have noted, the borderline patient's anger and depression have peculiar qualities.

How these two sources of confusion influence the descriptions of borderline affects becomes apparent when one examines some of the statements about depression in the literature. For example, there are frequent qualifying phrases used by those clinicians who note a predominance of depression. Cary (29) has noted that the borderline patient is characterized by a "sense of futility and pervasive feelings of loneliness and isolation" that he says do not constitute a "true" depression. Hoch and Cattell (17) stated that they found frequent secondary depressions due to the persistent illness in their pseudoneurotic patients, but that primary depressions were infrequent. Kernberg (23) noted the prevalence of depressive-masochistic character traits in some of his borderline patients but differentiated these from depressive symptoms. Further, he advised that depression "as a symptom should not be used directly as an indicator of borderline personality organization" but suggested that only severe depression approaching psychosis in the form of "ego depersonalization" should be a presumptive indicator for a diagnosis of borderline personality. Gruenewald (55) commented that there is often a "covert" depression that emerges later. Chessick (56) described a chronic "existential despair" in borderline patients.

Anger is less controversial than depression. Many authors have noted a prevailing anger in borderline patients. This one feature seems to have been used progressively to discriminate borderlines from the original description of the "as if" personality (3, 30) and from "schizoid" personalities (29), where withdrawal from

frustration is considered more characteristic. One author (57) felt that the borderline patient's anger is so prominent that he suggested changing the name to "choleric." Despite the apparent agreement about the prevalence of anger, such a broad range of behaviors is cited as being "angry" that a high degree of inference may be required. Some examples are hostility (50), rage reactions (31, 49), acting out (3), self-destructiveness (23, 31, 33, 58), detachment (59), mutism (33, 57), and demandingness (29, 57). Several authors have said that anger is not a presenting theme but one that emerges in the course of treatment (42, 50, 59). Kernberg (23) and Meza (57) speculated about excessive aggressive drive, while Modell (38) saw the anger as "mostly defensive."

In contrast, several authors have regarded anxiety as the typical affect shown by their patients. Hoch and Cattell (17) gave this anxiety the status of a "defining secondary diagnostic symptom." Although others (23, 32, 41, 47, 49) have also commented on anxiety in borderline patients, it is difficult in most instances to know if they are describing a symptomatic problem among borderlines or are making an inference based on a theoretical role given anxiety in personality theories.

Finally, another term frequently applied to borderline patients is anhedonia (32). In fact, there is considerable agreement that they lack a capacity for pleasure and rarely experience truly satisfied feelings. Their anhedonia has been discussed in terms of borderline dysphoria, unhappiness (47, 60), anguish (56), and lack of tenderness (3, 38).

In summary, the affective state of borderline patients is characterized by the prominence of anger and depression plus varying degrees of anxiety and anhedonia. If a generalization can be made, it is that these patients are not flat in their affect tone; they tend, in fact, to experience intense and variable affects, although this does not seem to include the experience of pleasure.

Behavior

Much of the literature on the treatment of borderline patients describes behavior during therapy, especially during hospitalization. Here we are interested in those behaviors which characterize borderline patients when they come for evaluation and that would therefore be used as criteria for making the diagnosis of borderline and in planning treatment. This is an important issue, since there may be a typical and highly distressing behavioral regression following hospitalization whose active prevention may be required from the start (21, 29, 31, 33, 35, 50, 61). Within the repertoire of hospital behaviors, such acts as window breaking, wrist slashing (31, 33, 58), and repeated overdosing (50, 62) emerge as quite specific to this kind of patient.

One historical factor, which led psychoanalysts to the conception of and interest in borderline patients as a distinct entity, was the discovery that many patients who by their histories and demeanors seemed relatively healthy underwent regressions on the couch. This disparity between good social behavior and poor intrapsychic structure has been mentioned repeatedly by both analysts (18, 48, 63, 64) and psychologists (28, 60, 65). What is meant by good social behavior seems to be good appearance and manners combined with superficial interpersonal relationships, and—more surprisingly—good functioning at work (12, 36, 42, 48, 60, 66, 67). The latter is surprising because this impression is noted almost in passing by many writers despite its apparent conflict with the behavioral record the patients have elsewhere in their lives. Schmideberg (47) took exception to this view. She described her borderline patients as marginal and transient in their work histories and cited their "sense of entitlement" as a source of their work problems. Grinker and associates summarized their follow-up data by saying, "Although gainfully employed and largely self-sufficient economically, the facts suggest that the group was occupationally and academically static at a fairly low level" (30, p. 132). Frosch (12, 66) noted that a borderline person may have a surprisingly stable work record when he is employed in a highly structured environment.

The characteristic most frequently and consistently ascribed to the behavior of borderline patients is that of impulsive and self-destructive acts. "Self-destructive" is used here to indicate a broad range of behaviors whose *result* is self-destructive although their intent or *purpose* is not. Examples include sexual promiscuity and perversions in search of affection (56, 68), self-mutilation with the goal of object manipulation (58, 61) or establishing self-identity (66), and addiction in search of escape (15, 32). Generally, borderline patients do not regard these behaviors as self-destructive, self-degradative, or guilt provoking. Although relatively little of the literature on borderline patients has dealt with actual suicide, repeated suicidal gestures and threats have been noted (50, 54, 57) and specific manipulative behavior attributed to such patients (69, 70).

Diverse sexual problems are attributed to borderline persons, but there is little agreement on their prevalence. Certain authors have noted a preoccupation with sex (17), and others have described polymorphous perverse sexuality (17, 23, 35, 46). Some authors (3, 12) have even included within the borderline category most persons with specific sexual deviances. Greenson (35) noted a "prominence of organ pleasures at the expense of object relations" among this group. Several authors (17, 41, 42) believe that these behaviors reflect a basic confusion in the sexual identity of the individuals.

The presence of obvious behavioral disturbances in a variety of spheres including drug use and sexual deviance often causes the borderline diagnosis to overlap with various character problem diagnoses in which chronic acting-out patterns such as antisocial, addictive, alcoholic, and homosexual behavior are seen. Because of this, Kernberg (71) has argued for a new classification of character types based upon what he believes are more fundamental personality features than behavior. He and many others have included a number of specific character disorders within the broader diagnostic category of borderline syndrome (21, 38, 41, 46, 47, 54, 68). Jan Frank (35) has sug-

gested that various acting-out behaviors provide outlets for many persons now diagnosed as borderline who previously would have become overtly schizophrenic. He and others (71, 72) believe that inadequate impulse control is the dominant ego defect in these persons.

One concludes that in considering the behavioral evidence for the diagnosis of borderline, a clinician should not be deterred by the presence of a stable work history or superficial social adequacy but should examine other areas, where he may often find evidence of impulsive sexual, drug-taking, or other activities whose results are self-destructive even though the patient's intent or purpose is not.

Psychosis

While there has been general agreement that borderline syndrome is a stable personality disorder (12, 23, 30, 33, 38, 39, 47), there is also widespread recognition that a number of these patients may develop psychotic symptoms (1, 17, 36, 39, 45, 46, 49, 51, 66, 73). Indeed, as indicated earlier, the borderline person's capacity to develop regressive psychotic symptoms may be a pathognomonic feature. Weiner would seem to concur with this conclusion in his review of the literature (28). However, there is a consensus that when psychoses do occur, they have the following differential features: 1) stress related (21, 23, 36, 43, 49, 68), 2) reversible (21, 30, 41, 49), 3) transient (12, 15, 30, 49), 4) ego-alien (1, 12, 30), and 5) unsystematized (23, 29, 30, 43, 45, 60, 74). Numerous authors have used some or all of these features to differentiate borderline psychoses from the psychoses of schizophrenia and other disorders (21, 23, 29, 30, 38, 45, 54, 66). Thus there is general agreement as to absence of stable or clear delusions or hallucinations, with only a few dissenting opinions (17, 33). Some authors have postulated that the borderline's psychoses occur in response to intolerable rage (29, 30, 41, 73).

Interestingly, despite the consensus about the vulnerability of certain borderline persons to psychotic-like episodes and regressions, only a few authors have viewed this as an essential feature of the borderline syndrome (1, 12, 45, 73, 75). Most authors have hastened to note that the occurrence of psychoses is the exception, not the rule (23, 29–31, 39, 46, 76). A few have taken a determined position that psychoses do not occur at all in borderline persons (33, 50, 63). At the opposite extreme, Hoch and Cattell (53) found that the psychoses in their sample of pseudoneurotic schizophrenic patients were not necessarily transient and reversible. A more recent report (77) suggested that the psychoses of this group cannot be differentiated from those of schizophrenics, and another (46) reported that they are brief and rare. This last report would thereby place pseudoneurotic schizophrenia within the mainstream of thought about psychoses among borderline persons.

There have also been widespread references to the similarity between the psychotic thought processes of borderline and schizophrenic persons. Some borderline persons demonstrate fears of being controlled (17), ideas of reference (38), externalization (1, 56), and other paranoid tendencies (12, 23, 56). Some writers have noted that they have vividly loose associations and other symptoms of formal thought disorder. For example, Knight (1) stated that loose associations can be detected by use of the Rorschach test and free-associative interviews. On the other hand, Grinker and associates (30) emphasized that they found no looseness of associations. (However, they did not use projective tests or free-associative interviews in their assessment of their patients.) Hoch and Cattell (17) took an intermediate position, stating that "approximate" or "parallel" associations are frequent. Thus there is little agreement among clinicians about the presence of thought disturbances in borderline persons. Some say there are none (23, 30), while others say there are many (1, 47, 50, 65, 73). It is clear that these differences result from problems in defining and assessing thought disorder as well as from the methodological problems cited earlier.

Some authors have underscored the frequent occurrence of disturbed states of consciousness. These peculiar ego states, which were first described by Deutsch (3), have been variously categorized as depersonalization, dissociation, and derealization (23, 29, 36, 45, 61, 66). They have been called borderline "states," to be differentiated from borderline "personalities." These states are seen as responses to anxiety (66), depression (23), and rage (29) and as prepsychotic experiences (3).

Separate from the purely clinical literature already summarized, a literature grew in the 1960s that recognized a vulnerability among borderline persons to psychoses when exposed to pharmacological stress, namely, that produced by marijuana (78), LSD (68, 79), and mescaline (68). These reports suggest that the borderline person is unique in his sensitivity to pharmacological stress. This special sensitivity or vulnerability seems to support Schmideberg's often quoted characterization of the borderline personality as "stably unstable" (47).

From the many foregoing clinical reports, which vary in their positions on whether psychoses occur among the borderline group, a series of clinical questions arise: Do all borderline persons have a vulnerability to psychosis even if they are not psychotic when assessed? Are most borderline persons free from psychosis throughout their life despite such a vulnerability? Clinicians are uncertain and divided over these issues. Grinker and associates (30) contended that psychoses occur in only one subgroup of borderline persons. Equally important, they are the only authors who have attempted to identify subgroups of borderlines who they contend will *not* develop psychoses. Other authors have implied or hinted that many or even most borderline persons could develop psychoses, given properly stressful circumstances. Parallel issues concerning the extent and type of their reality testing and the nature and type of their cognitive style will be considered in a later section of this paper.

To conclude, reports in the clinical literature generally agree that an undetermined number of borderline persons do develop psychoses in stressful situations. Moreover, when such psychoses occur, they are characterized by

their limited symptoms and limited duration. There are, however, few actuarial data on the prevalence of vulnerability to psychosis among borderline persons. Some authors have suggested that dissociative states may be quite marked in these patients.

INTRAPSYCHIC PHENOMENA

The psychological test literature devoted to characterizing borderline patients has generally been in agreement that they demonstrate ordinary reasoning and responses to structured tests such as the Wechsler Adult Intelligence Scale (WAIS), but that less structured tests such as the Rorschach reveal deviant thought and communication processes (27, 28, 43, 60, 74, 80–83). As in the clinical literature, most articles on which this conclusion is based are impressionistic. Their many methodological issues require attention before this broadly held viewpoint is accepted (6). The seminal contributions were made by Rorschach, Rapaport and associates, and Schafer, with subsequent authors generally being content to add confirmatory evidence.

Rorschach (5) and later Rapaport and associates (8) used the terms "fabulizing, combinatory, and confabulated" thinking to describe the propensities of borderline persons to overspecify secondary elaborations of their associations and to combine and reason oddly. They are prone to reason circumstantially rather than logically. Their separate perceptions tend to become intermingled and related simply because they occur close together in time or space. Borderline persons read more affective elaboration into their perceptions than others can validate, i.e., they tend to add too much and too specific affective material to simple perceptions. Other persons then have trouble accepting this affective meaning, although they might accept the same basic percept that the borderline person sees.

Rorschach, in 1921 (5), was the first to call attention to some seemingly adequately functioning persons whose responses to inkblot tests resembled those given by schizophrenic patients. He applied the term latent schizophrenic to those persons who had average surface behavior but Rorschach test features in common with schizophrenics, such as self-references, belief in the reality of the cards, scattered attention, variability in quality of ideas, and absurd and abstract associations.

It was Rapaport and associates (8) who first described the borderline person's intact performance on the WAIS and a pervasively odd Rorschach record; this has subsequently become an almost axiomatic diagnostic rule for later writers presenting single case studies. Although these authors defined two groups of what they called preschizophrenics, namely, the coarctated group and the overideational group, it has been largely the overideational borderline patient who is referred for psychological testing and upon whom subsequent literature has concentrated. Stone and Dellis (74) reiterated Rorschach's observation about the disparity between social functioning and thinking. They went on to confirm in a prospective study (74) Rapaport and associates' finding of a discrepancy between the Rorschach test and the WAIS in their evidence for pathology in borderline patients.

Schafer (82) introduced a third distinguishing feature about the disturbed thinking of borderline patients when he suggested that they are more comfortable about their bizarre and distorted thinking than are schizophrenics. Although Schafer's finding seems to differ from the general impression in the clinical literature that psychoses are ego-dystonic, it was later repeated in a report by Fisher (60).

In an interesting report DeSlullitel and Sorribas (84) compared the Rorschach test results of normal subjects, borderline persons, and creative artists. They found that the negative unpleasant content within "fabulized combination" responses by borderline persons distinguished them from the creative artists, who presented positive content within similar types of responses.

Gruenewald (55) reported on psychological test batteries given to 10 of Grinker and associates' original 51 borderlines five or more years after their discharge. She noted that based solely on test results, 2 would have been diagnosed as schizophrenic. However, when these data were combined with other information, the results were consistent with the borderline diagnosis and fit within the subgroups Grinker and associates had derived. She noted that "maladaptive primary process manifestations" were sometimes present in thought content and organization. Unfortunately, she made no mention of any discrepant functioning on individual tests.

In summary, borderline persons are believed to connect unrelated percepts illogically, overelaborate on the affective meaning of percepts, and give circumstantial and unpleasant associations to the Rorschach inkblots. This disturbed thinking may be more flamboyant and more ego-syntonic than that found among schizophrenic persons. Yet such borderline persons are reported to function adequately on the WAIS, showing few or none of the ideational deviances.

EGO FUNCTIONS

There are various ways to assess and classify ego functions. Thus it is difficult to select from the literature comparable descriptions of specific ego-function characteristics of borderline persons. However, two functions do emerge as particularly relevant to this group, namely, reality testing and interpersonal relationships. While the latter remains almost solely within the purview of clinical impressions, several approaches to evaluating reality testing have been made.

Reality Testing

Any discussion of psychosis is based upon the concept of reality testing. Frosch (12, 40) has stated that an intactness in reality testing differentiates borderline persons from schizophrenics. Distinguishing among reality testing, sense of reality, and relationship to reality, he

concluded that borderline and psychotic persons share a poor sense of reality and relationship to reality, but that the borderline person can test out his experiences whereas the psychotic cannot. In a panel report on the "as if" personality, a similar conclusion was reached about this subgroup of borderline persons (85). This position is akin to the frequent comments of several authors that borderline persons, when compared to schizophrenics, have more distance from their psychotic experiences and regard the episodes as ego-alien or ego-dystonic. Zetzel (21) added a twist to Frosch's viewpoint by stating that it is the capacity to reverse impaired reality testing, given a good situation (in treatment), that distinguishes borderline persons from schizophrenics.

A number of authors seem to agree with Frosch that reality testing is generally maintained in borderline persons (23, 30, 85). Wolberg (85) has stated that the reality distortions that do occur are defensive in nature and that the borderline person's actual perception of reality is always extant. However, Kernberg (51) has noted that "under special circumstances—severe stress, regression induced by alcohol or drugs, or transference psychosis"—they may lose this capacity. Kernberg and others have noted that these patients are prone to develop psychotic transference reactions. Of course, unless this feature is cited in the patient's history, it would not be of use in an initial diagnostic evaluation. Authors using psychological tests have assigned relatively greater importance to the vulnerability of the borderline person's reality testing to stress (31, 43, 60). Knight (1) noted the borderline person's inability to distinguish between dreaming experiences and reality. Hoch and Cattell (53) later drew a similar conclusion about the impairment in reality testing in their group of pseudoneurotic schizophrenic patients.

A number of authors have emphasized that reality testing should not be viewed as a phenomenon that one has or does not have but, rather, that there is a spectrum of reality testing (1, 16, 38, 50). Modell (38) and others (21, 23) have discussed the borderline person's reality testing problems in the context of self-object differentiation. Modell noted,

> The testing of reality depends upon the fact that in the ego's growth a distinction has been made between self and object .... there are degrees of alteration of this function of testing reality that correlate with the degree to which self and object can be differentiated .... the borderline transference is based on a transitional object relation where there is some self-object discrimination, but where this discrimination is imperfect. (38, p. 228)[2]

Such a graded view of reality testing helps to reconcile certain discrepancies noted earlier among authors who have presented contradictory views of reality testing in borderline persons.

As Hurvich (86) has pointed out, there is a need for quantifiable measurements of this ego function, which could be used to evaluate whether and to what extent impairment exists. Although Grinker and associates (30) included "relation to reality" as one of the seven ego functions they intended to evaluate in their borderline patients, they did not include any instruments to measure this directly. Their evaluation was based on behavior that was generally labeled as "positive" or "negative" and upon ratings of perception devised from global judgments of the patient's awareness of self, others, time, events, and things. These assessments did not give any consideration to latent vulnerability to disruptions in reality testing. Further, their validity as reflections of reality testing is not always obvious. Grinker and associates seemed aware of these problems and did not draw any definite conclusions about the relationship to reality and the capacity for reality testing in their sample. Until instruments or methods of measuring reality testing are developed, the literature on borderline persons will continue to reflect the ambiguity of the concept, and clinical impressions will be subject to the unstated and therefore unknown biases of the researchers.

At this time the consensus is that there is a definite impairment of reality testing in borderline persons, but it is not as severe as that in psychotic persons and, under most circumstances, is not apparent.

Interpersonal Relationships

A number of authors have pointed to borderline patients' style of relatedness as the most distinguishing diagnostic feature of this group. Zetzel (21) said that for the borderline patient in particular, "the kind of doctor-patient relationship that is established may prove to be a crucial factor in reaching a definitive diagnostic evaluation." This relationship is best illustrated by the following observations.

A frequently cited feature of the borderline patient's object relationships is a predictable superficiality and transiency (30, 32, 60, 87). Fisher (60) suggested that "superficiality in relationships" distinguishes borderline patients as a group from neurotic patients. Knight alluded to this somewhat differently by noting, "Other ego functions, such as conventional (but superficial) adaptation to the environment and superficial maintenance of object relationships, may exhibit varying degrees of intactness" (1, p. 6). This echoes the observation made earlier about the borderline person's surprising capacity for adequate social functioning but adds that this apparent behavioral normality may depend on superficiality. Dyrud (32) commented that case material cited by Grinker and others demonstrates more than anything else the remarkably short sequences of interactive behavior that these patients are capable of maintaining.

This quality of superficiality and transiency is supported and explained in some measure by the original formulations of the "as if" personality by Deutsch (3). Deutsch described the borderline person's interpersonal relationships as "plastic" and "mimicry." She stated that the "essential characteristic is that outwardly he conducts his life as if he possessed a complete and sensitive emotional capacity." Eventually, the absence of real emotional responsiveness leads to repeated dissolution of

[2]Burnham (61) has suggested that borderline patients frequently have pets or toy animals.

relationships. This disparity between adequate superficial relatedness and inadequate internal relatedness has been used to characterize borderline patients more generally (29, 30, 48–50, 60, 80). It may be attributable to a lack of coherent self-identity, which Grinker and associates (30) found in their sample and which other authors have also noted (1, 21, 23, 45, 49, 56, 66).

In contrast to the recurrent theme that borderline persons' interpersonal relationships are superficial and transient is the claim that they are prone to form intense, clinging relationships. Adler (31) stated that their "readiness to form rapid, intense, engulfing relationships" is what differentiates them from schizoid and schizophrenic persons. Similarly, Modell (38) stated, "My principal reason for considering this group homogeneous is that they develop a consistent and primitive form of object relationships in the transference." Grinker and associates (30) referred to this when they cited as one of the four identifying characteristics of borderlines "a defect in affectional relationships. These are anaclitic, dependent, or complementary, but rarely reciprocal." These accounts of borderline persons' intense relationships are underscored by the consensus that their initial relationships with therapists are dependent and demanding (12, 21, 23, 29, 31, 38, 50, 76). In addition, many authors have noted that the intense therapeutic relationship is characteristically devaluative and manipulative (21, 31, 38, 50, 57). The emergence of such angry behaviors may in turn lead to the repeated disruption of such close relationships (49, 50, 57). These qualities of the borderline person's close relationships may not be immediately discernible. Houck (50) pointed out that this initial deception can lead to later problems for unsuspecting therapists.

Thus in their everyday relationships borderline persons relate in a fairly normal but superficial and transient manner, while in their close relationships they become intense, dependent, and manipulative. In any event, these individuals are actively involved with other people and are not particularly socially withdrawn.

SUMMARY

In this paper we have surveyed the large literature of descriptive accounts of borderline patients. Within the major variations in these accounts we have attempted to identify certain themes and prevailing clinical impressions. We have discussed the four methodological issues that significantly influence the resulting descriptive accounts. Taking these methodological issues into account, we have identified a number of features that most of the authors believe seem to characterize most borderline persons. These features are as follows:

1. *The presence of intense affect.* It is usually of a strongly hostile or depressed nature. The absence of flatness and pleasure and the presence of depersonalization may be useful in differential diagnosis.

2. *A history of impulsive behavior.* This may take many forms, including both episodic acts (e.g., self-mutilation, overdose of drugs) and more chronic behavior patterns (e.g., drug dependency, promiscuity). Often the result of these behaviors is self-destructive although their purpose is not.

3. *Social adaptiveness.* This may be manifested as good achievement in school or work, appropriate appearance and manners, and strong social awareness. However, this apparent strength may reflect a disturbed identity masked by mimicry, a form of rapid and superficial identification with others.

4. *Brief psychotic experiences.* These are likely to have a paranoid quality. It is felt that this potential is present even in the absence of such experiences. The psychoses may become evident during drug use or in unstructured situations and relationships.

5. *Psychological testing performance.* Borderline persons give bizarre, dereistic, illogical, or primitive responses on unstructured tests such as the Rorschach, but not on more structured tests such as the WAIS.

6. *Interpersonal relationships.* Characteristically, these vacillate between transient, superficial relationships and intense, dependent relationships that are marred by devaluation, manipulation, and demandingness.

These six features provide a rational basis for diagnosing borderline patients. The criteria can be readily assessed during an initial evaluation. Further research is under way to evaluate the relative frequency and discriminating value of each of these features. From these studies a reliable system of diagnostic criteria can develop. It is hoped that such prestated and standardized means of identifying borderline patients will permit better treatment planning and clinical research on these patients to proceed.

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Alcohol Use in the Army: Patterns and Associated Behaviors

BY JOHN F. GREDEN, M.D., SINAI I. FRENKEL, PH.D., AND DONALD W. MORGAN, M.D., D.M.SC.

The authors assessed by questionnaire the alcohol use of 1,873 U.S. soldiers in the United States and Viet Nam. According to operational definitions based on total ethyl alcohol consumption and several behaviors associated with drinking, 7 percent were classed as alcoholics, 5 percent as borderline alcoholics, and 24 percent as potential alcoholics. Contrary to popular stereotypes, there was a disproportionate number of younger and lower ranking soldiers in these three groups; there was also a positive relationship between drinking and use of illicit drugs across groups. The authors state that future studies of alcohol use should include determinations of total ethyl alcohol intake to permit generalizability of their results.

ALCOHOL USE AMONG SOLDIERS has caused periodic concern throughout modern military history. In 1895, for example, the Report of the Surgeon General of the Army reflected the disturbing facts that "17 [military] posts had more than 10 percent of their average strength under medical care for drunkenness" and that the hospital admission rate for alcoholism was "41.43 per 1000 strength" (1, p. 2). However, assessment of alcohol-related "costs" has always been complicated by the paucity of accurate prevalence data (2, 3). Official therapeutic response to the alcohol problem has fluctuated, perhaps in correlation to these deficiencies of information. Summarizing earlier studies, Fiman and associates (4) stated that "preventive and treatment programs under medical auspices have not been systematically developed, although from time to time there have been programs in each branch of the military."

In the late 1960's, as part of the research response to developing patterns of illicit drug use, there was greater investigation of alcohol use among military personnel. The findings of these studies precipitated renewed interest in alcoholism research, treatment, and outcome evaluation. In 1972, this burgeoning concern culminated in the establishment of a major Army-wide program to counteract alcohol abuse (5–7). In support of this program, we initiated an epidemiological study of basic patterns of alcohol and illicit drug use among two populations of functioning soldiers—one in the United States and one in the Republic of Viet Nam (South Viet Nam). Specifically, this paper emphasizes operational definitions of groups of alcohol users based on drinking patterns and correlated behaviors and examines prevailing hypotheses about military drinking patterns.

The traditional stereotype of the military problem drinker seems to have been one of a middle-aged senior enlisted man. According to West and Swegan (2), a major dilemma for commanders was the "40-year-old master sergeant with 17 years of honorable service, who has passed across the vague borderline between heavy drinking and chronic alcoholism, and who now is becoming less effective but is still a valuable person." Fiman and associates (4) and Cahalan and associates (8) provided some documentation for this stereotypic profile. Cahalan and associates also identified the factors of being single, separated, or divorced and having less than a high school education as significant correlates of heavy drinking, but they did not find race to be a definitive factor.

Another behavior examined in a variety of reports on both civilian and military populations is the association between illicit drug use and heavy drinking. Despite subjective disclaimers from both drinkers and drug users that the two patterns are unique, a number of studies have reported a positive relationship between heavy alcohol use and excessive use of drugs, including methadone (9–11).

To consider these various issues, we examined several prevailing questions about drinking patterns in the military: Is there any validity for the stereotype of the military problem drinker as a middle-aged senior enlisted man? Can a current high-risk typology for functioning problem drinkers be formulated? Are illicit drug use and alcohol use distinct and separate patterns (as youthful drug users in the military have frequently claimed when attempting to differentiate themselves from "juicers"), or do the two patterns coexist?

METHOD

In July 1972, we simultaneously administered questionnaires that could be keypunched to active-duty functioning soldiers in the United States and Viet Nam. The U.S. sample consisted of 863 enlisted men at Fort Lee, Va.—approximately 4 percent of the total post population. The Viet Nam sample included 1,010 U.S. enlisted

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men stationed in Viet Nam—approximately 2 percent of the total American troop strength in July 1972. Only noncombat support troops (responsible for supplying, feeding, and maintaining installations and equipment for combat troops) were surveyed. In both locations, units were chosen randomly from available troop rosters solely on the basis of their availability during openings in our schedules. Cooperation was excellent: only five individuals in Viet Nam and two at Fort Lee chose not to participate in this voluntary survey.

Fort Lee is a military installation of approximately 15,000 active-duty personnel, located in central Virginia near Richmond and two smaller population centers. All respondents in the Viet Nam sample were located in the three primary areas of troop concentration at the time of the survey—Saigon, Long Binh, and Da Nang.

In both samples, respondents were surveyed in groups of 30 to 150 individuals assembled in or near their work or classroom areas. Command personnel were absent from the survey area during the approximately 20 minutes necessary to complete the form. During the introduction, we emphasized anonymity and our medical research orientation to help establish rapport. Each questionnaire consisted of 100 computer-tabulated multiple-choice items pertaining primarily to the individual's patterns of drug and alcohol use, demography, family and legal history, social and military adjustment, and need for treatment.

Classification Methodology

Two major factors were employed in the classification of respondents into subgroups: total quantity of ethyl alcohol consumed and the absence or presence of several behaviors characteristically associated with problem drinking.

To determine the quantity of alcohol consumed, each soldier's self-reported typical weekly consumption of liquor, beer, and wine was converted into total ounces of ethyl alcohol, the common denomination of alcoholic beverages.[1] The assumptions we used in these conversions were as follows:

1. Hard liquor contains 40 percent alcohol, and a shot (1 ounce) equals .4 ounces of alcohol.
2. Beer contains 5 percent alcohol, and one can (12 ounces) equals .6 ounces of alcohol.
3. Wine contains 12 percent alcohol, and one glass (3 ounces) equals .36 ounces of alcohol.

The quantities of alcohol consumed in the form of liquor, beer, and wine were summed to ascertain the individual's total weekly consumption of alcohol. In addition to this measure, selected behaviors used to define subgroups included several simple items often associated by other investigators with drinking: 1) drinking despite previous job trouble related to alcohol use, 2) drinking first thing in the morning at least once a week, and 3) drinking despite previous trouble in leisure activities due to alcohol use.

[1]In this report any reference to alcohol will mean ounces of ethyl alcohol converted from beverage alcohol.

Operational Definitions

The samples were arbitrarily divided into the five following mutually exclusive major groups on the basis of total alcohol consumption and related behaviors:

1. *Alcoholics.* This group included those respondents who consumed more than 50 ounces of alcohol a week (the equivalent of five commercial fifths of hard liquor) and those for whom drinking had caused job difficulties.
2. *Borderline alcoholics.* All respondents who drank 31 to 50 ounces of alcohol (the equivalent of three to five fifths of hard liquor) were included in this group.
3. *Potential alcoholics.* There were three subgroups in this category. The first consisted of respondents who drank 15 to 30 ounces of alcohol a week. The other two subgroups reported drinking less than 15 ounces of alcohol per week: one subgroup reported drinking first thing in the morning and the second subgroup reported drinking currently despite a history of problems in leisure activities due to drinking.
4. *Drinkers.* This group included respondents who reported drinking the equivalent of 1 to 14 ounces of alcohol a week without any history of alcohol-associated behaviors mentioned on their responses to the questionnaire.
5. *Rare or nondrinkers.* This group included respondents who reported that they drank rarely and those who totally abstained from alcoholic beverages.

RESULTS

There were striking similarities in the percentages of respondents falling in each of the nine subgroups for the Fort Lee and Viet Nam samples. For example, 4 percent of each sample reported drinking more than 50 ounces of alcohol a week and 3 percent described previous job trouble due to drinking, but reported that they continued to use alcohol. Percentages for each of the other seven subgroups were virtually identical for the two samples, and chi-square tests revealed no significant differences between the samples or any subgroups therein. Because respondents from the Fort Lee and Viet Nam samples reported such strikingly similar drinking patterns, they were combined and analyzed as one group.

To further simplify presentation, we will present data for only the five major groups rather than all nine subgroups. This is done because, as indicated previously, this paper focuses on patterns of alcohol use and associated behaviors for functioning soldiers in "representative" situations, rather than emphasizing comparisons between the Viet Nam and U.S. samples.

Distribution by Groups

According to our operational definitions, the distribution of the combined sample of 1,873 in the five major groups was as follows: alcoholics, 7 percent (N=131); borderline alcoholics, 5 percent (N=89); potential alcoholics, 24 percent (N=457); drinkers, 38 percent (N=712); and rare or nondrinkers, 26 percent (N=484).

TABLE 1
Comparison of Demographic Characteristics Among Operationally Defined Groups of Drinkers

Characteristic	Alcoholics (N=131)		Borderline Alcoholics (N=89)		Potential Alcoholics (N=457)		Drinkers (N=712)		Rare or Nondrinkers (N=484)		Total Sample (N=1,873)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age, in years*												
17–19	42	32	24	27	123	27	150	21	131	27	470	25
20–29	79	60	58	65	278	61	434	61	295	61	1,144	61
30 and over	10	8	7	8	56	12	128	18	58	12	259	14
Less than high school education**	39	30	18	20	91	20	85	12	63	13	296	16
Rank*†												
E1–E4	97	74	65	73	320	70	470	66	348	72	1,300	69
E5–E6	33	25	19	21	110	24	171	24	102	21	435	23
E7–E9	1	1	5	6	27	6	71	10	34	7	138	8

*A 5 × 3 chi-square analysis (df=8) showed significant differences among the groups on the variables of age and rank ($p<.01$).
**A 5 × 2 chi-square analysis (df=4) showed significant differences among the groups on the variable of education ($p<.01$).
†Ranks E1–E4 include private, private first class, and corporal; E5–E6 indicate sergeant and staff sergeant; and ranks E7–E9 include master sergeant, first sergeant, sergeant major, and command sergeant major.

TABLE 2
Comparison of Drinking Behaviors Among Operationally Defined Groups for the Combined Samples

Behavior	Alcoholics (N=131)		Borderline Alcoholics (N=89)		Potential Alcoholics (N=457)		Drinkers (N=712)		Total (N=1,389)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Began drinking before age 15*	69	53	32	36	132	29	135	19	368	27
Drinks more since entering Army*	84	64	52	58	210	46	221	31	567	41
Spends more than $5 a week on alcohol*	94	72	69	78	169	37	57	8	389	28
Drinks in morning at least once a week**	59	45	31	35	114	25	—	—	204	30***
Drinks hard liquor daily*	48	37	36	40	64	14	14	2	162	12
Misses at least one meal a week because of drinking*	63	48	41	46	105	23	64	9	273	20

*A 4 × 2 chi-square analysis (df=3) revealed significant differences for each of these items across drinking groups ($p<.01$).
**A 3 × 2 chi-square analysis (df=2) revealed a significant difference across drinking groups ($p<.01$).
***This percentage is based on a total number of 677 (rather than 1,389) because the 712 drinkers were excluded on the basis of operational definition.

Demographic Characteristics

Demographic characteristics for these five groups are given in table 1. Contrary to a common belief in the military, we found that noncommissioned officers over the age of 30 did not comprise a disproportionate percentage of the alcoholics and borderline alcoholics. In fact, a proportionately higher percentage of those under 20 years old and with ranks below sergeant were included in the groups with the heaviest alcohol consumption. Thirty percent of the alcoholics had not completed high school, compared with 16 percent of the total population.

In contrast to reported findings for illicit drug users, the demographic variables of race, marital status, and hometown population did not significantly differentiate among the drinking groups: between 68 and 73 percent of each of the groups were Caucasian, a range of 30 to 40 percent were married, and 37 to 44 percent were from towns of greater than 100,000 population.

Drinking Behaviors

To determine what types of alcoholic beverages each group drank in accumulating their total alcohol consumption, the percent drinking any liquor, beer, and wine, respectively, was obtained. Not surprisingly, a higher percentage of those designated as alcoholics reported drinking each of the three beverages (more than 90 percent were beer drinkers, 85 percent drank hard liquor, and 50 percent drank wine). Borderline alcoholics reported almost comparable patterns. Among the remaining three groups, the percent who consumed any hard liquor sequentially decreased, with only 48 percent of the drinkers reporting that they drank hard liquor.

Table 2 presents comparisons of drinking behaviors among the groups. The finding that more than half of the alcoholics said they started drinking before the age of 15 was striking; only 19 percent of the drinkers started before that age. A higher percent of the alcoholics also re-

ported drinking more since entering the Army. Alcoholics and borderline alcoholics consistently stated that they spent more money than the other groups on alcoholic beverages. This was, of course, consistent with operational quantity definitions. The finding that 28 percent of the alcoholics spent less than $5 a week on alcoholic beverages was initially puzzling, however. This could be partially explained by the fact that for five American dollars, a U.S. soldier in Viet Nam could buy approximately two and a half cases of beer or three fifths of liquor, and soldiers at Fort Lee could also purchase liquor at lower prices than in the civilian market. Thus, these soldiers could consume large quantities of alcohol cheaply. Forty-five percent of the alcoholics, 35 percent of the borderline alcoholics, and 25 percent of the potential alcoholics stated that they took a drink of alcohol the first thing in the morning at least once a week. Almost half of the alcoholics and borderline alcoholics also reported having missed one or more meals in the previous week because of drinking.

Family and Legal History

To compare drinking patterns with family history, we inquired about a variety of intrafamily relationships. Few significant differences were found among the groups in respondents' assessments of their own interactions with their parents and their appraisals of the relationship between their parents. A significant difference that did emerge was that a higher percentage of the alcoholics stated that their parents not only drank heavily but smoked heavily ($p<.01$, chi-square test). It should be noted that the percentages of each group reporting that their parents drank or smoked heavily were generally low, ranging from 20 to 3 percent across the groups. This family characteristic has been reported previously (12, 13).

Previous legal and social history also revealed that 44 percent of the alcoholics reported civilian convictions other than for traffic offenses, compared with only 16 percent of the total population ($p<.01$, chi-square test). A strikingly high proportion (14 percent) of the alcoholics had enlisted in the Army to avoid a jail sentence. With these previous patterns, it was not surprising that after entering the Army the alcoholics, borderline alcoholics, and potential alcoholics had significantly more administrative punishments and courts-martial than the other groups ($p<.01$, chi-square test).

Attitudinal Measures

In our investigation, we found that a significantly higher percent of alcoholics and borderline alcoholics said they were seldom busy on the job, found their jobs uninteresting, and were usually bored with their overall military situations ($p<.01$, chi-square test). A greater percent of alcoholics also reported feeling that their superiors showed little concern about the military mission, were not responsive to their individual needs, and that they subsequently did not feel free to talk with superiors about job considerations ($p<.01$, chi-square test). It was interesting to note that at least 50 percent of the alcoholics and borderline alcoholics, compared with 30 percent of the drinkers, felt that drinking on the job increased or did not change their ability to perform.

When asked whether they felt they currently needed help with a drinking problem, 12 percent of the alcoholics responded affirmatively. Only 4 percent of the borderline alcoholics and 3 percent of the potential alcoholics said they needed help. Essentially, this meant that 2.4 percent of the total population of 1,873 currently desired treatment for their drinking behaviors.

Use of Illicit Drugs

Table 3 clearly demonstrates a positive relationship between alcohol use and use of illicit drugs. For example, 68 percent of the 131 alcoholics reported previous use of marijuana. Among the other groups, the percentage of men reporting previous marijuana use tended to decrease as severity of alcohol use decreased, with only 39 percent of the rare or nondrinkers reporting this behavior. This pattern was consistent for each of the other drug types, including hallucinogens, stimulants, depressants, and heroin. An incidental finding was that heavier drinkers smoked tobacco more heavily than those groups with lower alcohol consumption.

Comparison of the Two Alcoholic Subgroups

As noted in our operational definitions, the alcoholics group consisted of two separate subgroups. Because of the implications of the label "alcoholic," we compared these two subgroups to determine if those respondents who consumed more than 50 ounces of alcohol a week were similar to those who did not consume this quantity of alcohol, but who reported previous job difficulties related to alcohol use. We found that these subgroups were essentially similar in most respects. The behaviorally defined subgroup drank less alcohol weekly than did the quantity-based subgroup. (This further explains why a higher percentage of the borderline alcoholics than of the combined alcoholics group spent over $5 a week on alcohol.) However, most of this subgroup did consume more than 30 ounces of alcohol a week, began drinking before the age of 15, drank more since they entered the Army, and drank in the morning at least once a week. Demographic characteristics and attitudes toward the military were similar for these two subgroups.

COMMENT

The major finding of this study was that a substantial 36 percent of the two samples we studied were classified as actual, borderline, or potential alcoholics. According to operational definitions, which relied primarily on quantity but also considered several simple behaviors associated with problem drinking, 7 percent of the population were categorized as alcoholics, 5 percent as borderline alcoholics, and 24 percent as potential alcoholics.

In 1972, Cahalan and associates (8) also reported that a high percentage of functioning soldiers had problems

TABLE 3
Comparison of Previous Use of Illicit Drugs Among Operationally Defined Groups of Drinkers

Drug	Alcoholics (N=131)		Borderline Alcoholics (N=89)		Potential Alcoholics (N=457)		Drinkers (N=712)		Rare or Nondrinkers (N=484)		Total Sample (N=1,873)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Marijuana*	89	68	52	58	283	62	363	51	188	39	975	52
Hallucinogens*	52	40	22	25	141	31	157	22	77	16	449	24
Stimulants*	58	44	30	34	174	38	164	23	92	19	518	28
Depressants*	43	33	22	25	128	28	114	16	68	14	375	20
Heroin*	29	22	16	18	68	15	107	15	39	8	259	14

*A 5 × 2 chi-square analysis (df=4) across each of the five drinking groups revealed significant differences on use of drug versus no use of drug ($p<.01$).

associated with alcohol use. They described 35 percent of enlisted men as problem drinkers and 32 percent as heavy or binge drinkers. Because they employed different techniques, populations, and operational definitions, direct comparisons between this study and their findings were not possible, but the basic similarities are clear.

The first ancillary hypothesis tested in our study was not confirmed—namely, the stereotype of alcoholics in the military as primarily older, upper rank enlisted men. In this connection, it must be emphasized that respondents to our survey were functioning soldiers, not designated patients.

In response to the second question we studied, it was possible from our data to identify a current high-risk typology for problem drinking. Essentially, the soldier at high risk in this population was young (17–19 years old), low ranking, and less educated (i.e., had no high school diploma). This typology has previously been observed for both drug and alcohol use in military studies (10, 14).

The reemergence of drinking among young people has also been described recently in the mass media (15). Despite this recent emphasis on alcohol consumption among youth, military medical clinics and alcohol programs continue to describe alcoholics as older individuals (4, 16). This probably stems from the fact that it takes a number of years of heavy drinking combined with the aging process to produce the pathophysiology that prompts an individual to seek attention and permits a rigid diagnosis of alcoholism (17). Nevertheless, epidemiological profiles among functioning soldiers—rather than designated patients—emphasize an urgent need for innovative primary and secondary preventive programs for this youthful segment of the military population.

We found in examining our third question that heavy drinkers in our samples unequivocally reported greater use of all the major types of illicit drugs. A higher percentage of alcoholics than of the other groups reported use of marijuana, hallucinogens, stimulants, depressants, and heroin. A sharp distinction between "juicers" and "heads," therefore, was not confirmed by this study and appears to originate more from desired social identity of the users than from actual patterns of drug use.

To place these findings in proper perspective, it must be noted that our study was conducted during hot summer months, which may have greatly influenced consumption of alcoholic beverages, especially beer. Variables related to climate and season should undoubtedly be considered in future surveys of drinking behaviors. Also, the population we surveyed consisted of noncombat troops, and there may be differences between this group and soldiers in combat status. Furthermore, a relevant factor when considering age in any epidemiological study of drinking in the military is that selection procedures for advancement in the Army may skew the population by weeding out certain types of drinkers. For example, the heavy drinker without exceptional skills may be administratively or medically separated, or the disinterested heavy drinker may voluntarily terminate his military career.

Attempts to compare our findings with those from similar studies proved extremely difficult. Surveying the literature, we discovered that researchers have utilized a wide array of yardsticks in assessing drinking behaviors, a pattern that makes generalization and cross-validation difficult, if not impossible. Common denominators for problem drinking are genuinely difficult to agree upon. Admittedly, total quantity of ethyl alcohol consumed is just one parameter—and not always the most important—but it appears to be the only measure that can be universally applied in epidemiological studies of alcohol use. In future evaluations, innovative behavioral and psychological analyses should be encouraged, but a common feature of all studies, whatever their emphasis, might be the measurement of total quantity of ethyl alcohol consumed. Data from several large studies could then be accumulated and collapsed, distributions and standard deviations could be compiled, and some generalizability might finally be attained in studies of alcohol use.

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Sensorimotor Functions and Cognitive Disturbance in Psychiatric Patients

BY GARY J. TUCKER, M.D., EDWARD W. CAMPION, M.D., AND PETER M. SILBERFARB, M.D.

The authors studied 109 consecutive admissions to an acute psychiatric unit in a general hospital to determine the relationship of specific sensorimotor impairments to cognitive disturbance. The results indicated a strong but not exclusive correlation between neurological impairment and thought disorder as well as between neurological impairment and schizophrenia. The theoretical and etiological implications are discussed, as well as the relationship of these findings to other variables.

SCHIZOPHRENIA REPRESENTS a psychopathological condition with clear cognitive disturbance (thought disorder). The present study investigates the role of specific sensorimotor impairments to cognitive disturbance. Although an attempt was made to examine schizophrenic patients specifically, cognitive disturbance is not exclusive to these patients (1). Consequently, a large group of patients was examined for this disturbance, but the major theoretical basis for this study relies primarily on studies of schizophrenic patients.

Neurological studies of adult schizophrenic patients have shown varied results, but if the criteria of soft or minor neurological signs (nonlocalizing) are used, in contrast to hard or major signs (localizing), there is evidence of neurological dysfunction in adult schizophrenia. Pollin and associates (2) and Hertzig and Birch (3) performed detailed neurological examinations on adolescent and adult schizophrenic patients and found more soft neurological signs in these patients than one would expect by chance. Increased soft neurological signs in schizophrenic patients have also been found by Kennard (4), Larson (5), and Rochford and associates (6).

Rochford and associates studied 65 hospitalized patients for the presence of the following soft signs: motor impersistence, stereognosis, graphesthesia, extinction to bilateral simultaneous stimulation, bilateral marked hyperreflexia or hyporeflexia, coordination defects, disturbance of balance and gait, sensory abnormalities, movement disorders, speech defects, abnormal motor activity, auditory visual integration, choreiform movements on the adventitious motor overflow tests, and cranial nerve abnormalities (such as slight aniscoria, esotropia, eighth nerve deficit not proven audiometrically, and mild visual field and retinal defects). Hard signs consisted of localizing findings of CNS abnormality such as lateralizing cranial nerve findings, pathological reflexes, unilateral sensory deficits and movement disorders, and unequivocal abnormal electroencephalograms. Rochford noted that neurologic abnormality was found in 36.8 percent of all patients studied, a finding significantly different from a control population of normal subjects. Interestingly he found no neurological abnormality among patients with affective disorder. The neurologic soft signs were found in a significantly greater number of the schizophrenic patients (65.5 percent) (6). Pollin and associates (2) noted that 72.5 percent of their schizophrenic patients had at least one sign; this percentage compares favorably to 65.5 percent in the study by Rochford and associates.

The high incidence of soft neurological signs in schizophrenic patients is difficult to ignore. The most frequent types of neurologic abnormality in the schizophrenic patients were defects in stereognosis, graphesthesia, coordination, and balance and gait and some movement disorder other than choreoathetosis. There was also some difficulty in auditory-visual integration of perceptual stimuli that may relate in part to the cognitive defects often evident in schizophrenic patients.

This study attempts to study the relationship between cognitive disturbance and sensorimotor functions and to evaluate whether this association is exclusive to patients with a schizophrenic diagnosis or whether there is a stronger relationship between sensorimotor impairment and cognitive disturbance than previously believed.

METHOD

The sample consisted of 109 consecutive admissions to the acute inpatient service of the Dartmouth-Hitchcock Mental Health Center during a six-month period (July to December 1972). The average age of the 109 patients was 32.9 years; 74 (68 percent) were women and 35 (32 percent) were men. They had an average of 12.9 years of education. All patients admitted to the inpatient service were tested except those who had a history of alcoholism, clear-cut neurological illness, treatment with ECT, or toxic psychosis or were below the age of 16 years or above the age of 60 years. To avoid some of the problems of diagnosis, the patients were classified as schizophrenic or nonschizophrenic on the basis of their scores on the

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Schneider First Rank Symptom Scale (7) and the New Haven Schizophrenia Index (8). Their premorbid social behavior was determined by the use of two scales, the Phillips Prognostic Rating Scale (9) and the Klein Scale of Asocial Behavior (10). Other data collected included the Spitzer scale for psychiatric symptoms (11), routine developmental data, neurological history, and medications used (past and present). These interviews were performed by a separate clinician.

Shortly after admission, a separate tester who had no knowledge of the patient's history or diagnosis administered the Goldstein-Scheerer Object Sorting Test to each patient to assess cognitive disturbance. An experienced neuropsychological technician, who was unaware of the other results, gave standard tests for finger agnosia, finger-tip writing, and tactile form recognition (12, 13) and the Halstead Tactual Performance Test (14) for tactile performance. Patients were tested as soon after admission as possible (usually within 72 hours) and generally showed excellent cooperation with these procedures.

The Goldstein-Scheerer Object Sorting Test was administered and scored in the same manner used in previous investigations (1, 15, 16). The total number of objects sorted in seven trials and the patient's reasons for the sorts were recorded. Each patient received an overall score from 1 (normal) to 5 (markedly abnormal) on scales for overinclusive, idiosyncratic (or bizarre), and underinclusive thinking. The two independent raters who scored the results showed an interrater reliability of 91 percent. A score of 4 or 5 on either overinclusive, underinclusive, or idiosyncratic scales was classified as thought disturbance.

An experienced neuropsychologist analyzed the performances on each of the four neurological tests. From a frequency analysis of the results and comparisons with normal controls, a scale was devised so that a score of 1 (normal) to 4 (most abnormal) could be assigned to performance on each test. These scaled scores were then combined to form the following neurological impairment index: normal, 0–6; possible mild impairment, 7–8; mild impairment, 9–11; and moderate impairment, 12–16. Appropriate nonparametric statistical analysis was applied.

RESULTS

Of the 109 patients, 65 (59.6 percent) showed evidence of abnormal cognition on at least one of the scales of the object sorting test (see table 1). The predominant disturbance was overinclusive thinking, evident in 51.3 percent (N=56) of the patients studied. Idiosyncratic thinking and underinclusive thinking were much less common; they were present in 12.7 percent (N=14) and 9.1 percent (N=10) of the patients, respectively. Forty-five patients or 41.3 percent showed mild to moderate neurological impairment. If those with possible mild neurological impairment were included, this number went up to 57 percent of the patients. As only those with overinclusive thinking manifested a statistically significant relationship with neurological impairment ratings (p=.02, Spearman rank correlation), the subsequent data analysis is based on the overinclusive thinking scores.

In addition to the correlation of overinclusive thinking and neurological impairment, neurological impairment ratings correlated significantly with increasing age, with both measures of schizophrenia (New Haven Schizophrenic Index and Schneider's First Rank Symptom Scale), and with the number of previous psychiatric hospitalizations (p=.02, Spearman rank correlation). It is of interest that neurological impairment did not correlate significantly with scores on the Klein Scale of Asocial Behavior or the Phillips Prognostic Rating Scale. The data for younger age groups (16 to 25 years) and older age groups (25 to 39 years and 40 to 60 years) indicate that neurological impairment increases with increasing age. There is no statistically significant difference in the neurological impairment index in the two older groups between those with or without cognitive disturbance. However, there is a statistically significant difference in the younger age group (16 to 25 years); those with cognitive disturbance had a much higher neurological impairment index than those without cognitive disturbance (8.4 versus 5.5, p=.03, Mann-Whitney u test).

There were no significant differences between those who manifested cognitive disturbance and those who did not in terms of neurological problems or indicators (e.g., past history of convulsions, head injury, stuttering, and trouble in school with either reading, writing, or arithmetic). Impaired performance on the tactile form test, finger agnosia, and finger-tip writing, but not on the tactile form recognition test, correlated significantly with overinclusive thinking (but this was not an exclusive relationship).

The significant correlation of both measures of schizophrenia are consistent with previously reported findings in schizophrenic patients, as noted above, and will be discussed more extensively in a subsequent report. However, although the schizophrenic patients comprised only 34 percent (N=38) of the total patient sample, they comprised 50 percent (N=22) of those patients with neurological impairments (N=45): 57.8 percent (N=22) of the schizophrenics (N=38) had mild to moderate neurological impairment (table 1); 68 percent of the schizophrenics with thought disorder had neurological impairments; 41 percent of the nonschizophrenics with thought disorder had neurological impairment; but only 25 percent (N=10) of the nonschizophrenic patients without thought disorder had neurological impairments. These results indicate a strong but not exclusive relationship between neurological impairment and thought disorder as well as between neurological impairments and schizophrenia (see table 1).

DISCUSSION

Both thought disturbance and functional neurological impairment are present in hospitalized psychiatric patients, and this relationship exists unrelated to diagnosis, occurring in both nonschizophrenic and schizo-

TABLE 1
Comparison of Patients' Neurological Impairment with Cognitive and Diagnostic Measures (N=109)

Category	Number	Neurological Impairment Index				Chi-Square Value (df=3)
		Normal (0–6) (N=47)	Possible Mild (7–8) (N=17)	Mild (9–11) (N=24)	Moderate (12–16) (N=21)	
Overall cognitive disorders						
None	44	23	9	8	4	< 7.01*
Any disorder	65	24	8	16	17	
Specific cognitive measures						
Overinclusive thinking	56	19	7	14	16	< 8.61**
No overinclusive thinking	53	28	10	10	5	
Idiosyncratic thinking	14	6	0	5	3	< 1.20
No idiosyncratic thinking	95	41	17	19	18	
Underinclusive thinking	10	4	1	2	3	< 0.60
No underinclusive thinking	99	43	16	22	18	
Diagnostic categories						
Schizophrenic	38	9	7	10	12	<10.49***
Nonschizophrenic	71	38	10	14	9	

*p=.07.
**p=.03.
***p=.01.

phrenic patients. Although thought disturbance as measured in this study was more common than would be expected, certainly the incidence of 41.3 percent of neurological impairment in psychiatric patients is even more surprising. However, the tests for neurological impairment and thought disturbance are very specific and precise measures of functions that are usually not evaluated carefully in routine clinical evaluation. These results are noteworthy because the criteria for neurological and cognitive impairment were stringent and biased toward the extremes of abnormal performance. The fact that only 36 percent of the sample by either diagnostic criteria or 22 percent by both were schizophrenic indicates that both these impairments occur in nonschizophrenic patients as well. Our findings of a high incidence of neurological impairment in schizophrenic patients is consistent with previous studies (2, 3, 6, 17–19).

To interpret these findings the following questions must be answered: Are the neurological impairments only a reflection of normal aging? Are the measures of cognitive disturbance and neurological impairment measuring the same parameters? What is the role of medications? Certainly one would expect increasing neurological deficits with increasing age. Our data reflect this in part but may indicate other factors also. The chronicity of the illness and the effects of repeated hospitalizations and their attendant treatments may be concomitants of age and thus confound this relationship. That neurological impairments are significantly related to previous hospitalizations also connotes some factor relating to chronicity or severity. The fact that the neurological impairment is significantly greater in younger patients with cognitive impairment also attests to some particular relationship between these factors. All of these findings (cognitive disturbance, neurological impairment, previous hospitalizations) may also relate to severity of illness. Lillistón (20), in an interesting study, noted that the schizophrenic patients who showed more evidence of organic dysfunction on psychological tests also have more psychiatric symptoms. Similarly, Kennard (21) noted that in those patients with EEG abnormalities there was a higher incidence of disordered thinking. Therefore, although age cannot be ruled out, it cannot be the entire explanation.

Certainly one must ask whether or not the sensorimotor tests used in this study and the object sorting test are not measuring similar functions. Most people consider the object sorting test a test of concept formation necessitating adequate vision and the ability to form operational concepts (22). In addition, this test requires a degree of visual form perception in the same way that the sensorimotor tests require tactile form perception, sensory integration, and speed of performance. However, it would still seem unlikely that in this case the tests used are tapping similar functions. The object sorting test as used here was scored primarily on the basis of the patient's verbal interpretation of their sorts, e.g., on their ability to form concepts about why they sorted in such a manner. It was not scored on the basis of number of objects handed over by the patient; instead, the patient handed over the objects and then was asked why he did this. His subsequent responses were then scored for the degree of overinclusive, idiosyncratic, or underinclusive thinking. The sensorimotor tests (the tactile form recognition, finger-tip number writing, tactile performance test, and finger agnosia) required almost no verbal behavior or concept formation. Rosenbaum (23) tested various psychomotor behaviors in schizophrenic patients. He noted that while the schizophrenics could be discriminated on the basis of their performances on these psychomotor tests, especially weight estimation, they could not be differentiated when other perceptual modalities, especially auditory functions, were tested. Consequently, it would seem unlikely that the psychomotor tests employed by Rosenbaum are evaluating precisely the same functions as the sorting tests used in this study.

Although the relationship of medications, which nearly all these patients were taking (95 percent), must be considered a relevant variable, some patients taking the same medications had no cognitive disturbance or neurological impairment. Previous studies (24–26) have shown that the use of phenothiazines tends to lessen cognitive disturbance. Small and associates (27), using the Halstead-Reitan battery to demonstrate the effects of various treatments including ECT, phenothiazines, and lithium, observed no change in serial testing other than improvement in most areas. Also, the specific incidence of impairment in the schizophrenic patients is strikingly similar to the findings of Rochford and associates (6), whose sample was tested prior to drug use.

IMPLICATIONS

Certainly the association of cognitive impairment and neurological disturbance is not surprising in itself, as this is quite common in organic brain syndromes (28, 29). However, these patients are not clinically "organic," but only on detailed testing show minor sensorimotor impairments that have not previously been associated with cognitive disturbances; in both schizophrenia and organic brain syndromes, cognitive or thinking disturbances are evident perhaps more than in any other clinical condition. It is unfortunate that under these rubrics, e.g., cognitive or thinking disturbances, many different and similar defects have been described, some of which supposedly differentiate the two conditions (loose associations, symbolic-logical defects, etc.), and some which overlap (concreteness, disorganization) (29). Several studies (22, 30) have noted that in formal testing some schizophrenics will manifest thought disturbance while others will not; therefore, the presence or absence of thought disorder may relate to an as yet unclear second factor. Perhaps the presence of neurological impairments, related either to those demonstrated here or to others, may be the necessary factor for the occurrence of thought disorder. Overinclusion was by far the most prominent thought disturbance noted in the present sample, both in the schizophrenic and nonschizophrenic patients. This type of thinking disturbance might be a more pervasive disturbance, prominent during many different types of cerebral or behavioral dysfunction, while the bizarre, idiosyncratic, and personalized responses could more often be related to specific types of schizophrenia or psychosis. It is also possible that the more idiosyncratic responses need a more directed or focused inquiry or even relate to emotionally laden interpersonal interactions. Sophisticated neurological and psychological examinations of patients manifesting various types of thought disturbance seem mandatory. More precise definitions of terms such as "thought disorder" and "neurological impairment" are also needed. Perhaps descriptions of supposed defects rather than the use of labels may be more important in communicating about and furthering our understanding of these conditions than the use of these (typically) personally defined terms.

The meaning of the relationship of these sensorimotor dysfunctions and thought disturbance is still unclear, regardless of their occurrence in schizophrenia. Are these incidental findings related to either the treatments or the chronicity of the illness and its subsequent social isolation and institutionalization, or are they basic to the illness process or common properties of people who develop schizophrenia or thought disturbance? Longitudinal studies are necessary to integrate and understand the diffuse array of neurological findings that seem to be consistently reported in schizophrenic patients. Many of the sensorimotor dysfunctions may relate to some disturbance in the relationship of the person with the world, or, more broadly, they may relate to the area of functioning we call cognition. If we consider schizophrenia to be primarily a defect in thinking, as many have, then some biological deficits in the mechanisms used to assimilate information from the external world would be consistent with the hypothesis.

Previous studies by Petrie (31), Houpt and associates (16), and Silverman (32) showed that schizophrenic patients tended to reduce incoming stimuli. These authors postulated that schizophrenic patients are defective in the processing of incoming stimuli and that psychiatric patients, particularly those with thought disturbance, have difficulty in integrating perceptual sensory inputs and in the processing of these stimuli. Although this theory is intriguing, many studies indicate a decrease in many cerebral functions, e.g., decreased vestibular responses to various stimuli, hyperregulation of the EEG, etc. (29). All of these cerebral functions and the neurological impairments we have noted may be related to a generalized process of cerebral inhibition leading to many of the symptoms of thought disorder, specifically psychosis.

CONCLUSIONS

A number of studies indicate an increased incidence of soft signs or central nervous system functional impairment in psychiatric patients, particularly schizophrenic patients. In this study we demonstrate a correlation between similar neurological impairments and cognitive disturbances. We have previously stated that the cognitive disturbance measured by the Goldstein-Scheerer Object Sorting Test occurred in nonschizophrenic patients also (1, 15). It is clear that there is a stronger association between cognitive disturbance and neurological impairment than has been previously noted, particularly with respect to overinclusive thinking. This association seems more important than the association with traditional diagnostic categories.

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Utilization Review of Treatment for Suicide Attempters

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The authors describe an effort to develop criteria for utilization review of treatment for suicide attempters. Explicit criteria proposed by a panel of experts as essential determinants for hospitalization of these patients were compared with actual clinical practice. It was found that according to the experts' criteria (which were operationalized into rating assessments), over half of the outpatient sample should have been hospitalized. After multiple regression analysis was carried out on the criteria, however, four predictors showed that only 20 percent of the outpatients should have been hospitalized. The authors discuss the issues these findings raise about the criteria of the experts, their utility for research, their validity, and their implications for utilization review.

UTILIZATION REVIEW, which is now a standard part of medical practice, has only recently been introduced into psychiatric care (1–4). The difficulties in monitoring the quality of psychiatric care are major. There is lack of agreement about what type of information is relevant, how the information should be collected and interpreted, and what the appropriate outcome measures are.

In 1969 the psychiatric utilization review and evaluation project (PURE) was undertaken by a group composed of members of the departments of psychiatry, epidemiology, public health, and sociology of Yale University and members of the psychiatric staff from the Connecticut Mental Health Center. This group began the task of developing a basic utilization review program for patient care evaluation in a community mental health center.

Various ways of approaching the problem of creating a mechanism for the continuous monitoring of the propriety, effectiveness, and quality of patient care services were suggested. They included the following: 1) development of screening devices to select cases for review; 2) development of adequate guidelines (or explicit criteria) by panels of experts for the evaluation of care; 3) development of more adequate instruments for data collection; 4) assessment of factors involved in the actual process of evaluation of care by the reviewing physician; and 5) use of epidemiological surveys and follow-up studies to monitor patient care beyond the period of the patient's institutional stay.

As part of the project various panels were formed, one of which was organized to develop criteria for evaluation of care given patients with suicidal behavior. This panel used the criterion-oriented approach described in detail by Tischler and Riedel (5). Based on a review of patients' charts and on their own clinical experience and knowledge of the literature, the panel developed implicit norms that were then translated into explicit criteria for the hospitalization of patients exhibiting suicidal behavior. They developed nine criteria for which suicide attempters should be hospitalized and conducted a prospective study to compare these criteria with actual clinical practice.

This paper has several purposes. We intend to describe the nine criteria and how they were translated into operationalized assessments that could then be studied, to test the validity of the criterion-oriented approach by comparing the explicit criteria for psychiatric hospitalization with actual hospitalizations, and to explore alternate ways of refining the explicit criteria so that they might be more suitable for utilization review.

METHOD

Treatment Setting and Criteria for Selection

The prospective study took place in New Haven, Conn., at the Yale-New Haven Hospital and the Connecticut Mental Health Center. The main source of patients was the emergency room of the hospital, which at the time of the study provided the main resource for acute treatment for suicide attempters in the New Haven area. The staff were linked with the emergency services of the adjacent mental health center. During the day, crisis patients might be seen at either resource; at night they were seen only in the emergency room.

The study included all patients aged 16 or over who

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came or were brought to the emergency services with a history of a suicide attempt or a suicidal gesture within the past three days. A suicide attempt was defined as any intentionally self-inflicted injury (including self-injuries by ingestion) unless there was good evidence both in the circumstances and in the patient's statements that there was not even partial or ambiguous self-destructive intent. Lack of intent was not assumed merely on the basis of the patient's denial, absence of serious risk to life, or added manipulative elements. It was accepted in cases such as attempted abortion by pill ingestion and cases of compulsive minor self-mutilation. Cases of accidental self-injury in which unconscious self-destructive intent was suspected were excluded in our definition of a suicide attempt because the injury was not intentional.

Included in our definition were suicidal gestures in which initiating moves of a potentially self-destructive nature had been carried out even if there was no risk of significant physical injury, e.g., climbing on a bridge, toying with a gun, announcing intent to ingest pills but actually taking no more than one or two. Some kind of act was required; patients only complaining of suicidal feelings, no matter how intensely, were not included.

Screening Procedures and Sampling

Screening took place over a period of 25 weeks, from November 1970 to May 1971. During this time psychiatric residents were instructed to identify and record data on all eligible subjects appearing at any time of the day or night on all days of the week. As a check on this procedure a research assistant examined emergency room records and other admission records daily to identify missed subjects. The appropriate resident was immediately contacted and the relevant information obtained in the event of missed cases.

During the 25 weeks, 274 subjects were identified and at least some data were obtained on each of them. The average inflow was 11 cases a week. Twenty-five patients hospitalized for medical sequelae of suicide attempts were excluded from the study because the disposition choice was a medical unit, and one patient was excluded because of insufficient data. This left a sample of 248 suicide attempters. Characteristics of the sample and the methodology have been detailed elsewhere (6).

Data Collection

Data were collected primarily by the psychiatric resident who first evaluated the patient clinically. After pilot studies had been carried out a precoded data-recording form was devised.[1] This form contains 101 items, including sociodemographic status, previous history, details of the attempt, judged and acknowledged motivations, mental status, social circumstances, what treatment was instituted, and residents' feelings toward the patient. Definitions of items and anchor points for each item's description rating were given in as much detail as possible. Items were adapted from a variety of sources, particularly the Los Angeles Suicide Prevention Center Assessment of Suicidal Potentiality (7), and, for mental status, a modified version of the Hamilton Rating Scale for Depression (8).

The form was completed by the psychiatric resident during or immediately after the initial interview with the patient. Almost all suicidal patients were seen by a psychiatrist when they first came to the emergency unit. For patients who were too physically ill or drowsy at this time, information was obtained after admission. Variables that referred only to the time of admission, such as mental status, were omitted. Thirty-two of the original 274 patients (11.6 percent) were discharged or died before information was obtained. For these patients, only basic sociodemographic data and treatment disposition were recorded. All of the data collected were recorded on precoded forms suitable for computer analysis.

RESULTS

Table 1 shows the criteria for hospitalization of patients with suicidal behavior developed by the expert panel as well as the translation of these criteria into operationalized rating assessments and operationalized criteria. These were administered as part of the resident's interview. Most of the criteria could be operationalized, but there was some redundancy.

Disposition Groups

The 18 operationalized criteria were rated on different scales, most of which were 4-point scales. Each scale was divided into two groups (e.g., high or not high, present or absent) according to the clinicians' judgment of the scale's reflection of the clinical situation. This dichotomization was done by a psychiatrist (L.K.) before the data were analyzed and was independent of the prospective study. A cross-tabulation of each of the 18 items was made with the three possible treatment dispositions.

Table 2 compares the operationalized explicit criteria with the treatment actually recommended. The items are ordered by their power to discriminate among the three groups.

Suicidal risk was the single most powerful item determining whether the suicidal patient was to receive a recommendation of hospitalization. It was found that 80.8 percent of the 121 patients who were hospitalized were considered high suicidal risks while only 25.7 percent of the 127 patients who were not hospitalized were considered suicidal risks. Eleven of the 18 items showed a significant prediction in the direction that the expert panel hypothesized. However, item 4b, "change from usual state," was a significant predictor in the opposite direction. A person having this symptom was more likely to have had an actual disposition of outpatient treatment than to have been hospitalized, although the experts judged that the presence of this behavior requires hospitalization.

The expert panel had agreed that the presence of any one of the criteria necessitated hospitalization. It is evident from the data shown in table 2 that all of the suicidal

[1]This form is available from the authors on request.

TABLE 1
The Experts' Explicit Criteria, Their Operationalization into Rating Assessments, and Operationalized Criteria

Experts' Explicit Criterion	Operationalization of Rating Assessments*	Operationalized Criterion
1 A clear lethal suicide plan	1a How specific was the plan for the attempt and its execution?	Specific plan
	1b How intense has recent suicidal behavior been?	Intensity of attempt
	1c What were the social circumstances of the attempt?	Help sought
	1d Using all available data from the interview, what is assessment of the patient's intent to kill himself?	Serious intent
	1e Taking into account all of the evidence, what was the potential risk of the attempt to the patient's life?	Serious risk
	1f What were the medical effects of the attempt?	Major medical effects
	1g What is the patient's acknowledged overt intent in making the attempt?	Overt intent
2 A recent history of medically serious attempts	2a How many attempts has the patient made in his entire life, including this present episode?	Previous attempts
	2b How many suicide gestures has the patient made in his entire life, including this present episode?	Previous gestures
3 The presence of suicidal thoughts, gestures, or attempts in association with delusions or psychosis	To what extent does the suicidal behavior show the following motivations:	
	3a Bizarre motivation?	Bizarre motivation
	3b Depressive delusions?	Depressive delusions
	3c Paranoid delusions?	Paranoid delusions
	3d Thought disorder?	Thought disorder
4 A recent progression in seriousness of thoughts from suicidal thoughts to gestures	4a How rapid was the onset and development of the present suicidal preoccupation?	Speed of onset
	4b How much do recent suicidal feelings and preoccupation represent a change from the patient's usual state?	Change from usual state
	4c How long had the patient delayed between deciding to take his life and making the attempt?	Plans delayed
5 An expectation of hospitalization that cannot be changed during interview	5 What is assessment of the risk of suicidal behavior by this patient in the near future?	Suicidal risk
6 The presence of high-risk social circumstances, such as social isolation	6 What are the patient's living arrangements?	Living arrangements
7 A current, clear suicide attempt	7a through 7g: same as 1a through 1g	Same as 1a through 1g
8 Expression of strong suicidal thoughts with intent and without seeing any other way out	None	—
9 Expectation of change in behavior of significant others due to suicidal behavior not met; change cannot be accomplished appropriately	None	—

*The rating scales were generally 4-point scales with definite anchor points.

patients in this study had at least one of the symptoms and that according to the experts' criteria all 248 patients should have been hospitalized. Thus the 127 patients (51 percent) who were not hospitalized would have, by the experts' criteria, been subject to utilization review.

Multiple Regression Approach

In an effort to determine which combinations of items were most important to determine disposition in actual clinical practice, all 18 items were entered into a stepwise multiple regression analysis. Disposition was transformed into a dichotomous variable: the inpatients were given a score of 1 and noninpatients a score of 2.

Four items were determined to be significant by the multiple regression analysis: suicidal risk, thought disorder, serious intent, and major medical effects. These items accounted for 38 percent of the variance in predicting disposition. It must be noted that the suicidal risk item accounted for 31 percent of the variance; the value of the three additional items was therefore small. Using all four items, 51 of 248 patients (20.5 percent) were considered misclassified: 15 hospitalized patients who were predicted not to require hospitalization by the criteria and 36 nonhospitalized patients who were predicted to require hospitalization. Thus, using these four items, the charts of 51 patients would be open to utilization review.

TABLE 2
Comparison of Operationalized Explicit Criteria for Hospitalization and Actual Disposition (N=248)

Criterion	Actual Disposition: No Further Treatment Number	No Further Treatment Percent	Outpatient Treatment Number	Outpatient Treatment Percent	Hospitalization Number	Hospitalization Percent	Chi-Square Value*
Suicidal risk							
High	8	38.1	27	25.7	97	80.8	70.7**
Low	13	61.9	78	74.3	23	19.2	
Serious intent							
Serious	3	14.3	3	2.9	34	28.3	26.2**
Not serious	18	85.7	100	97.1	86	71.7	
Overt intent							
Overt	6	27.3	43	42.2	79	69.9	23.6**
Not overt	16	72.7	59	57.8	34	30.1	
Previous attempts							
One or more	1	5.0	17	16.5	47	42.0	23.0**
None	19	95.0	86	83.5	65	58.0	
Thought disorder							
Present	1	4.8	2	1.9	25	21.2	21.2
Absent	20	95.2	102	98.1	93	78.8	
Serious risk							
High	4	18.2	6	5.8	35	28.9	20.1**
Low	18	81.8	98	94.2	86	71.1	
Intensity of attempt							
High	2	9.5	7	6.7	33	27.7	18.1**
Low	19	90.5	97	93.3	86	72.3	
Bizarre motivation							
Present	1	4.8	5	4.9	25	21.6	14.7**
Absent	20	95.2	97	95.1	91	78.4	
Specific plan							
Present	3	14.3	5	4.8	26	22.4	14.0**
Absent	18	85.7	99	95.2	90	77.6	
Major medical effects							
Yes	1	4.5	0	—	10	8.3	9.1***
No	21	95.5	105	100.0	111	91.7	
Plan delayed							
Yes	6	30.0	28	26.9	50	45.5	8.3***
No	14	70.0	76	73.1	60	54.5	
Living arrangements							
Bad	3	13.6	11	10.5	25	21.0	4.7
Good	19	86.4	94	89.5	94	79.0	
Depressive delusions							
Present	1	4.8	3	2.9	9	8.0	2.8
Absent	20	95.2	101	97.1	103	92.0	
Paranoid delusions							
Present	1	4.8	4	3.8	8	7.2	1.2
Absent	20	95.2	100	96.2	103	92.8	
Previous gestures							
One or more	4	19.0	21	20.4	28	25.2	0.9
None	17	81.0	82	79.6	83	74.8	
Help sought							
No	1	4.8	3	2.9	4	3.4	0.2
Yes	20	95.2	100	97.1	115	96.6	
Speed of onset							
Rapid	20	100.0	96	92.3	98	87.5	3.7
Not rapid	0	—	8	7.7	14	12.5	
Change from usual state							
Yes	19	90.5	83	79.8	65	57.0	18.1**
No	2	9.5	21	20.2	49	43.0	
Any of the above							
Present	22	100.0	105	100.0	121	100.0	
Absent	0	—	0	—	0	—	

*df=2.
**p<.001.
***p<.05.

DISCUSSION

Operationalizing the Criteria for Research

The findings show that the general guidelines developed by the experts could, with some exceptions, be operationalized and tested in a prospective study. Two of the nine criteria were not operationalized: criterion 8, "expression of strong suicidal thoughts with intent and without seeing any other way out," and criterion 9, "expectation of change in behavior of significant others due to suicidal behavior not met; change cannot be accomplished appropriately." However, operationalizing criterion 5, "an expectation of hospitalization that cannot be changed during the interview," called for a similar evaluation of the patient's expectations and future suicidal behavior. It would appear that the absence of operationalized assessments for these two criteria indicates a deficiency in the design of the prospective study.

There was some redundancy in the operationalized criteria, e.g., the "specific plan" criterion, and criterion 7, "a current, clear suicide attempt." This redundancy probably reflects the fact that the clinicians did not think in terms of operationalizing behavior. Greater attention must be paid to developing distinguishable explicit criteria so that translation into operationalized assessments will allow for testing of specific criteria with little overlap between variables.

Validity of Criteria

The validity of the criteria still remains a question. Was using the experts' opinion or using the clinical practice a valid approach? One way of determining the answer might be to look at the consequences of each approach. If the experts were correct, all of the suicide attempters should have been hospitalized and the 51 percent who were not hospitalized were misclassified. There is a body of literature (9–12) which agrees with the experts that all suicide attempters should be hospitalized. Two studies (9, 10) found that most attempters referred for outpatient treatment never actually begin treatment. Another study (11) showed that untreated suicide attempters are at higher risk for a future completed suicide than treated suicide attempters. In some parts of Great Britain it is the practice to routinely hospitalize all suicide attempters (12). Taken together, these studies suggest that outpatient treatment may be inadequate for suicide attempters.

If, on the other hand, the clinical practice not to hospitalize all 248 suicide attempters is valid, then the experts' criteria are too conservative. A number of problems could be seen in the British practice of hospitalization and in the experts' criteria. Of practical concern is the number of beds necessary to hospitalize all suicide attempters. Furthermore, a number of suicide attempters would be encouraged to identify with a sick, dependent role and look to hospitalization as an escape rather than try to cope with their conflicts. A third area of objection arises from the ethical and legal aspects of imposing hospitalization on a person who does not want it.

One way of determining whether or not the experts' criteria are valid would be a long-term follow-up study to see what happened to the 127 nonhospitalized patients in comparison with the 121 hospitalized patients. If the nonhospitalized patients had a poorer outcome (repeated suicide attempts and/or completed suicides), the experts' criteria should be considered more valid than clinical practice.

Implications for Utilization Review

The main purpose of this study was to develop criteria for utilization review of patients with a wide range of suicidal behaviors. Misclassified patients include those hospitalized patients who should not have been hospitalized ("overtreated") and those patients not hospitalized who should have been hospitalized ("undertreated"). According to the experts' explicit criteria, 127 of 248 patients (51 percent) were considered misclassified and should have been hospitalized. After multiple regression analysis, four operationalized guidelines determined that 51 of the 248 patients (20.5 percent) were misclassified: 15 (6 percent) were "overtreated," and 36 (15 percent) were "undertreated."

By refining the experts' criteria with multivariate techniques, the task of utilization review shifted from examining why 127 patients were not hospitalized to examining 51 charts. This seems to be a feasible task. Questions concerning the 15 patients who were "overtreated" would include whether they represent a discrete group with other characteristics that led to their hospitalization or whether they were truly a misclassified group. Similarly, it seems practical to begin reviewing the charts of the 36 "undertreated" patients rather than 127 charts and to focus on whether these 36 patients have characteristics which might explain their receiving less than adequate care. This is a particularly important group to examine in view of the high risk of a future successful suicide. Further work remains to be done on the application of the four criteria derived from the multivariate analysis to other treatment settings.

CONCLUSIONS

According to these results, the use of experts to develop guidelines for utilization review in psychiatry is feasible, at least with the treatment of suicide attempters. In general, criteria could be operationalized and tested. While the experts' criteria appear more conservative than actual practice, long-term follow-up studies are required before conclusions can be drawn. The combination of experts' criteria to develop baseline variables and multivariate analysis of the variables predictive of actual practice offers an approach to this complex problem.

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Obstacles in the Treatment of Dying Patients

BY PERITZ LEVINSON, M.D.

Theory and practice in the management of the dying patient have moved forward in the past two decades. However, the author believes the benefits of this progress have not reached a large segment of the population of dying patients—those individuals who have a higher level of psychopathology or are from a lower socioeconomic group. Obstacles in the treatment of such patients are described and illustrated by case histories; the author makes specific recommendations related to the care of these more difficult cases.

THE TREATMENT of the dying patient has gained systematic attention only during the past two decades. Despite the brevity of this period, there have already been three distinct historic phases. During the first phase, well-integrated patients who generally qualified for psychoanalysis were studied. During the second phase, treatment of the dying patient was extended to a larger but still selective group of middle-class individuals. The current or third phase of modern thanatology is facing the challenge of bringing the treatment of the dying patient to all individuals regardless of psychopathology, socioeconomic status, race, or religion. In order to accomplish this, obstacles in the treatment of these dying patients must be carefully delineated and confronted. In this paper, I will describe these obstacles, provide illustrative clinical cases, and make recommendations for dealing with them.

REVIEW OF THE LITERATURE

The First Two Phases

The first phase in the recent history of treating dying patients coincided with the appearance of *The Psychiatrist and the Dying Patient* by Kurt Eissler in 1955 (1). Eissler's book was associated with a decided quickening of interest in thanatology. The treatment of dying patients recorded in this volume was careful, thorough, and well documented. A number of detailed clinical studies in this style followed (2–5), and landmarks were charted in the feelings of the dying patient, his methods of coping with death, and the relationship to his doctors. These studies dealt with only a small minority of the population of terminally ill individuals. These individuals were, for the most part, young, intelligent, cultured, mature, reality-based, and responsive, with high levels of frustration tolerance and good capacities for object relations. They did not display the characteristics of isolation, dependency, immaturity, distrust, superstition, and lack of education that frequently appear in the general population.

The second phase was exemplified in the work of Elizabeth Kubler-Ross, whose book *On Death and Dying* (6) appeared in 1969. This study, which took place at Billings Hospital in Chicago, sampled a highly religious middle-class group of individuals who were invariably mature, hard-working, self-sacrificing, verbal, responsible, family-oriented people with roots in the community. Like the cases in Eissler's book (1), these cases are not suitable as models for the treatment of the dying patient in the general population because they do not reflect the significant limitations in relatedness, emotional stability, intelligence, and accomplishment that are found in the general population.

The Third Phase: The Problem Today

There have been several other books about the dying patient in recent years. These have either been general reviews with little or no clinical material (7–13) or have included "normal" economically favored subjects (14, 15).

A large group of individuals, characterized by higher psychopathology and lower socioeconomic status, have not yet benefited from our increased interest and proficiency in the management of the dying patient, as Sudnow (16) has illustrated. He described the care of the terminally ill in a 440-bed county general hospital that treated mainly indigent patients, many of whom were black. The nature of the organization did not require assumption of any extended responsibility to particular patients and their families, as would normally be found in a private hospital. "... alcoholic patients ... [patients] from lower-class settings, prostitutes, suicidal cases, vagrants, narcotic addicts, and the like, when encountered in grave borderline illnesses, were normally accorded a more rapidly fatal fate. These patients were [viewed as] less interesting [and] less deserving" (16, p. 206).

In an earlier work, Shands (17) described a similar trend in the tumor clinic of the Massachusetts General Hospital, Boston, Mass. He found that many cancer patients dropped out because the traditional shifting of clinic staff led to frequent disappointment in their efforts to form a needed dependent relationship. Other reports

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have shown that the adequacy of case management decreases with sociocultural distance between the clinician and his patient (18).

FACTORS LEADING TO OBSTACLES IN TREATING DYING PATIENTS

A number of factors can lead to obstacles in the treatment of the dying patient by causing abnormal mood states, excessive regression, negativism, acting out, abuse of medication, and countertransference reactions on the part of the staff. I have found the following factors most likely to lead to complications in the treatment of the dying patient: 1) severe ego deficiencies in the areas of frustration tolerance, contact with reality, and cognitive function; 2) pathological coping mechanisms that lead to withdrawal, isolation, suspicion, and conflict with doctors, clergy, family, and hospital staff; 3) the nature and severity of the physical disease; 4) religious, socioeconomic, cultural, and racial barriers; 5) lack of cooperation by the family; 6) iatrogenic factors stemming from the physician's unresolved feelings about death and his frustrated omnipotence; and 7) shortcomings in the patterning of medical care. Chronic schizophrenia and mental subnormality, which were included under factor 1, accounted for 3 cases in my sample of 14 patients. Factor 2 was a steady feature in the borderline psychopathology that characterized most of the remaining subjects in the cases I observed. A discussion of borderline traits that present obstacles to treatment precedes case histories illustrating these factors.

Borderline Traits as Obstacles

While the number of psychotic patients in the general population is not large, the incidence of borderline individuals is considerable. In the population of dying patients there are also stable character disorders that have decompensated under the stress of mortal disease. The borderline patient who is terminally ill often shows an excessive use of denial, coupled with marked deficiencies in such ego functions as self-observation, reality assessment, perception, integration, and communication. There is a lack of tolerance for anxiety and other affects, making it impossible to go through a process of protest and mourning (19). These patients find it difficult to feel concern for their objects and to feel guilt. Their reactions take primitive forms of rage and impotence rather than mourning and regret over aggression. They tend to withdraw from too close an emotional involvement, which lends a shallowness to their lives.

Other characteristics associated with the borderline level of psychopathology are obsessive and compulsive mechanisms, hypochondriasis, paranoid trends, and schizoid traits. These elements often present overwhelming barriers to the establishment of the working relationship that is necessary to effectively help the dying patient. An obsessive borderline patient tends to intellectualize the experience of dying, to employ isolation to excess, and to regress into an ideational rather than relational world. A hypochondriacal patient may be preoccupied with symptoms rather than relationships and may even feel relief and a sense of vindication because his illness is a "real" disease.

The patient with paranoid character traits is likely to react to his progressive organic disease with heightened distrust and suspicion that is fed by growing anger, despair, frustration, and helplessness. The individual with a schizoid tendency reacts with increased withdrawal, seclusiveness, and fantasy preoccupation. These reactions present formidable obstacles to the physician who attempts to care for a dying patient during his terminal illness.

Patients who present a narcissistic personality structure often have functioned very well prior to their disease, despite an inordinate need to be admired, a shallow emotional life, and a tendency to exploit their objects. Under the stress of terminal illness, they feel extreme envy and despair, and their enhanced distrust and depreciation of others leaves them completely unable to depend on anyone. The ravages of disease often increase their underlying rage and lead to the appearance of paranoid traits that further impede the staff's efforts to help them.

Other borderline-type traits include the impulse neurosis—a form of character pathology that finds expression in alcoholism and drug addiction among the general population. Such patients' pursuit of drugs for terminal pain is particularly difficult to manage. This group of patients merges with the "acting-out" personality disorders, which present a particular proclivity for suicide. Finally, there is the passive-dependent personality, who is often lonely and pessimistic and manifests a deep sense of futility and hopelessness.

The following sections will describe patients I studied who presented obstacles related to the factors I have enumerated.

PATIENTS STUDIED

While engaged in psychiatric consultation in a large general hospital, I focused on referrals that presented obstacles in the management of the dying patient. These "more difficult" cases were selected from cancer patients referred from two services—ear, nose, and throat (ENT) and hematology. During a two-year period, I studied a total of 14 individuals—8 surgical and 6 medical cases. They represented only those consultees who had not accepted recommended psychotherapy but who could be partially followed anyway, or those who initially accepted contact but then broke it off on one or more occasions. In each case, the cancer was at least moderately advanced and the prognosis was poor. Eleven patients died within two to six months after referral. There were 9 men and 5 women, with an average age of 46. Every subject I studied was seen for at least six sessions and most patients had many more sessions. In addition, there were consultations with medical staff, social service, family, and clergy.

The ENT subjects were generally referred by the nurs-

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ing staff because they were not experiencing the level of feeling associated with fatal disease. They usually manifested stoicism or excessive depression. The hematologic referrals were usually made by the attending physician and were often associated with untoward emotional reactions to chemotherapy with such drugs as cortisone, cyclophosphamide (Cytoxan), and vincristine sulfate. The undue stress precipitated or underscored existing psychopathology.

There are significant differences that cannot be overlooked between the patients with progressive tumors (many of them treated surgically) of the ENT service and those with the intermittent, invisible cancers of the blood system (20). However, patients with these diseases share a common ground when it comes to coping with death.

Case Reports

In the first case I will describe, excessive use of denial and paranoid mechanisms formed a serious obstacle to treatment. The second case deals with a borderline patient with severe acting-out tendencies.

Case 1. A 61-year-old truck driver was dying of metastatic carcinoma in the neck region. Although he had had extensive surgery, the patient employed massive denial toward his fatal disease, and he displaced all feelings of concern onto a chronic shoulder ailment caused by neuralgia. His frustration, anger, and helplessness resulting from the progressive debilitation were projected onto physicians, whom he viewed as sadistic, negligent, and inadequate.

Another important obstacle in establishing a relationship with this patient stemmed from his pseudomasculine and anti-intellectual attitudes, which were related to his social class. He viewed emotional illness or even talking about feelings as a sign of weakness and as a cause for ostracism. Therefore, he presented overwhelming resistance to behavioral consultation, whether from a nurse, social worker, or physician. In addition, he was suspicious of all educated people and of any process that smacked of intellectualism. He employed total denial of a marked sense of intellectual, social, and economic inferiority and of fears of rejection and passivity. In his decline, he presented an ongoing and grandiose monologue of former physical strength, emotional stability, and vocational feats.

Case 2. A 29-year-old narcissistic and masochistic divorced housewife had leukemia for two years before she died. The disease, combined with her psychological immaturity, led to a series of emotional crises for which the internist insisted on psychiatric treatment. However, on each occasion she rejected the contact after a few sessions. Her object relationships had been consistently shallow and conflictual, and she had always maintained an infantile attitude toward her mother. These infantile needs were greatly intensified by her fatal disease and led to a period of promiscuity. Intense envy of others' health as well as rage at her mother, who had failed to protect her from the disease, led to much guilt and to an all-consuming sado-masochistic relationship with a lover. The therapist was an instant recipient of primitive transference wishes and of sadistic projections that made it difficult to alter the acting-out behavior. The patient's children suffered abuse and neglect as a result of her acting-out behavior.

In certain cases, religious, cultural, social, and racial factors can pose a formidable barrier in the treatment of the dying patient. Religion provides a harmonious means of coping with death for some people. Usually, religion emphasizes the importance of an afterlife, and it thus detracts from the finality of death and eases mourning and the need to withdraw the libidinal cathexes from love objects. Devoutly religious people often charge the image of God with libido that is freed in anticipation of entering a new world, and these individuals are often best served by the clergy. However, the dying patient who finds himself in the borderline area between religion and rationalism can provide formidable obstacles to therapy. Such patients can become skeptical of religious doctrine but at the same time view the therapist as too rationalistic, challenging, and threatening. Culture-bound patients often view the therapist as an outsider. Competition between agents of the different disciplines can develop.

Obstacles arising from racial differences can occur in such situations as treatment of a black patient by a white physician. In this situation, the physician becomes the recipient of a hostile transference based on the patient's too often real experiences of rejection and exploitation.

The third case illustrates a barrier to the treatment of the dying patient that resulted from cultural factors. A deficiency in the patterning of medical care was an additional obstruction in this case.

Case 3. A 20-year-old woman who had dropped out of high school and become involved with the counterculture was dying of Hodgkins' disease. She rejected psychiatric consultation in favor of a faith healer who was popular in the counterculture milieu. The patient terminated an important course of chemotherapy at the insistence of the faith healer. This proved to be an unfortunate choice, as the disease, which had carried a hopeful prognosis if given intensive treatment, returned after four months and led to rapid decline and death. The patient's weakened physical state limited subsequent psychiatric intervention, although her disillusionment with the faith healer made psychotherapy more acceptable to her. Guilt and anger in regard to the faith healer added further stress by increasing her depression and distrust, both of which posed additional obstacles in her treatment. The impasse was compounded when the patient was sent to a cancer hospital for her terminal phase in order to free a bed on an acute surgical ward. She was deprived of her familiar surroundings as a result of deficient medical care patterning and staff countertransference based on her earlier refusal to cooperate.

Lack of cooperation by family members can pose another important obstacle in the treatment of the dying patient. The impasse can be formidable, as the patient often finds himself very dependent on his family and deprived of his authority (if he has not already surrendered it). The final clinical example I will present illustrates the dramatic interplay of a combination of factors that can provide formidable obstacles to treatment. The two main elements in this case are the special nature of the organic process itself and iatrogenic factors.

Case 4. An attractive 24-year-old woman died of carcinoma of the maxillary sinus with extension to the eye and skull after a

one-year course of the disease that featured marked oscillations in the prognosis. The patient had been referred for psychiatric treatment because of the tragedy of "a beautiful girl having to lose her face," as noted by the nurses, who identified heavily with the patient.

Psychiatric treatment began after the first surgical procedure confirmed the diagnosis and the poor prognosis. The patient had a strong inclination toward denial but nevertheless began to express feelings of protest, anger, and despair in a brave effort to cope with her disease and arrive at a stage of acceptance. However, members of the medical staff revealed deep feelings of grief, helplessness, and guilt. They began to avoid the bedside on rounds and were not able to maintain an accurate prognostication in response to the patient's appeals. A second operation was scheduled and, although she was faced with mutilation, the patient revived denial, stopped coping with the inevitability of death, and discontinued psychotherapy. The operative procedure, which inflicted great suffering, involved the resection of large segments of the palate, maxilla, and orbit, as well as removal of the eye. The patient was left with great pain and was unable to eat due to the loss of the palate. She became malnourished and frail, and before she could get accustomed to the cumbersome oral prosthesis, the tumor had recurred.

The nature of the cancer that caused a young woman—heavily dependent on her looks for admiration, support, and relationships—to lose her face represented a special obstacle to treatment. As the true nature of her prognosis became only too clear to her again (after the reappearance of the tumor), the patient wanted to resume the psychiatric treatment, but she felt too ugly and ashamed. When I was finally admitted to the bedside, I immediately asked to see her unbandaged lesion and made sure not to flinch at the gruesome sight.

The patient began to drop denial and resume her confrontation with death. However, the medical staff could not be dissuaded from once again offering hope in the form of cryosurgery which they heavily rationalized. Denial was iatrogenically reinstated and by the time the patient recovered from the procedure, she was too weak to continue her efforts to arrive at an accommodation with death. She died with a feeling of hopelessness, futility, and distrust.

TREATMENT RECOMMENDATIONS

The approach to the more difficult dying patient consists of three parts: 1) dealing with the patient himself, 2) providing consultation for the personnel who care for the dying individual, and 3) influencing official attitudes and policies regarding death and dying.

Very limited goals must be accepted in the treatment of such patients. A good therapeutic relationship in the traditional sense cannot be expected. Instead, the therapist and staff often meet with distrust or apathy. The passive approach to therapy that may encourage ventilation in better integrated patients is viewed by these individuals with suspicion and seen as disinterest, condescension, foreboding, or pity. There is no time with the more difficult dying patient to work through borderline traits in the usual way. The therapist should quickly sense the patient's suspicions and insecurities and actively try to alleviate them.

Preoccupation with physical symptoms is another limiting factor. Support, reassurance, and relief of the physical symptoms for these patients takes precedence over communications related to death, separation, and loss. Flexibility is important. While confronting rigid defenses in one patient, the therapist should be agile in responding to more fluid and changing impulses, affects, and defenses in another. The therapist may need to attenuate denial, counter withdrawal and apathy, sanction dependency, encourage protest, and combat excess depression —all within a brief span of time. Pathological defenses usually must be supported rather than challenged, and respect for the borderline patient's need for distance must be maintained. Suicidal intent may appear at any time. The treatment should be supportive, directive, and educative rather than interpretive.

The therapist should be able to use psychopharmacologic agents and analgesics with skill and imagination. Phenothiazines can decrease paranoid and schizoid symtomatology and also reduce the amount of analgesic needed. Inordinate depression may warrant the use of antidepressant medication. The therapist must be familiar with cancer treatment agents, their side effects, and their expected efficacy. Variability in the course of the organic process is an important factor to consider (21). Concern over death and dying increases with the progression of the disease and quickly fades as symptoms diminish due to spontaneous remission or active treatment intervention.

It is particularly urgent that the psychiatrist establish rapport with the primary care physician when the dying patient is a more difficult case. This is necessary because they must coordinate what the patient is told about his fatal illness and be responsive to each other's suggestions about analgesia, palliation, etc. The psychiatrist should serve an educative function for the primary physicians who themselves must care for most dying patients. It should be demonstrated that the emotional needs of the dying can be responded to within reasonable amounts of time. This instruction can be given informally during daily rounds as well as through case presentations during grand rounds. Subtle departmental influences that quietly discourage a young house staff member from "sitting with" a dying patient should be uncovered. Discussion by the medical and nursing staffs of their feelings about death, as well as their attitudes toward "psychos" and socioeconomically and morally deprived individuals, can be valuable in modifying iatrogenic factors in the treatment of dying patients (22).

To influence official attitudes, efforts must be made to recognize the dying patient's special needs. Public funding should be sought for research and the development of varied programs. Then, each case could be carefully screened and a decision made as to whether psychiatric treatment was needed and, if so, what type of therapy should be given. At the same time, another decision would be made as to whether the patient was suitable for treatment on a general ward, a cancer ward, a terminal care hospital, or at home. Public and private health insurance should compensate physicians for the additional time required by the emotional needs of the dying, and the family should be covered for specific expenses from

caring for the patient at home during the terminal phase.

Finally, it is important to equip the medical student with the ability to recognize and respond to the emotional needs of the many terminally ill patients he will encounter. Along the same lines, continuing education programs for practicing physicians should promote the theory and practice of thanatology. All of these efforts should receive confirmation by the appearance of appropriate questions on licensure examinations, specialty board examinations, and during periodic review.

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A Schizophreniform Behavioral Psychosis Mediated by Dopamine

BY DAVID L. GARVER, M.D., R. FRANCIS SCHLEMMER, JR., JAMES W. MAAS, M.D., AND JOHN M. DAVIS, M.D.

The authors conducted a study in which schizophrenic-like behavioral disturbances were induced in members of a macaque social colony by the chronic administration of d-amphetamine. Animals given the drug showed hypervigilance, hyperactivity, fragmented and repetitive behaviors, and progressive social withdrawal as well as the development of solitary stereotypies. The syndrome was dissected pharmacologically with alpha-methyl-para-tyrosine, chlorpromazine, pimozide, and haloperidol. Based on the behavioral findings and the known mechanisms of action of these drugs, the authors conclude that the major elements of the psychotic-like behavior induced by d-amphetamine were mediated by dopamine systems.

A SYNDROME VIRTUALLY INDISTINGUISHABLE from paranoid schizophrenia has resulted from street use or supervised administration of large quantities of amphetamines in amphetamine abusers who had no evidence of prepsychotic conditions (1, 2).

Similarly induced and similar appearing behavioral alterations in nonhuman primates could provide an animal model of psychosis from which much information could be gleaned concerning the function and interrelationships of critical neurotransmitter systems. Documentation of such psychotic behaviors may be possible through observation and quantitation of alterations in the rich variety of social interactions and individual behaviors induced by the administration of d-amphetamine to members of a nonhuman primate social group.

METHOD

Adult feral stumptail macaques with stabilized social relationships were observed in their colony at the same hour daily. Behavioral scoring encompassed both social and solitary measures. Each animal, in rotation, was scored during a 30-second interval with regard to 15 social and 13 solitary behaviors (there were 12 such intervals for each animal during each daily scoring period). Details of the scoring procedure appear in appendix 1. We will focus mainly on the following behaviors: activity —the number of intervals scored daily when movement other than checking occurred; stereotypies—the number of intervals when repetitive, often rhythmic behaviors (excluding checking or athetoid-like movements) that interrupted normal social or individual activities occurred; proximity—the number of intervals when the animal was less than three feet away from another animal; and checking—the total number of changes in eye direction or visual fields, with or without accompanying head movements, that occurred in 12 30-second intervals each day.

Four selected monkeys within the social colonies were given 2 mg/kg of d-amphetamine in time-release form (Dexedrine) every 12 hours via nasogastric tubing for a period of 3 to 20 days. Quantitation of behaviors was determined during the predrug period (baseline) and then again during the days when d-amphetamine was administered.

After a recovery period of at least 3 weeks from any previous study the same animals were pretreated via nasogastric tube with the following drugs immediately followed by the addition of d-amphetamine: 125 mg/kg of alpha-methyl-para-tyrosine (AMPT) every 12 hours for 14 days before d-amphetamine was given; 6.5 mg/kg of chlorpromazine (CPZ) a day for 36 days before addition of d-amphetamine; 0.5 mg/kg of pimozide (PZ) a day for 4 days before d-amphetamine addition; and 0.14 mg/kg of haloperidol a day for 21 days before addition of d-amphetamine with a stepwise increase in haloperidol to 0.57 mg/kg a day during days 17 to 20 of d-amphetamine administration. Finally, the animals again received two additional courses of 3 days of administration of d-amphetamine alone for comparison with earlier d-amphetamine-induced and drug-modified behaviors.

RESULTS

Syndrome Induced

Chronic administration of 2 mg/kg of d-amphetamine every 12 hours induced profound alterations in the behavior of members of the macaque social colony who received the drug. These animals manifested a state characterized by increased activity, frequent changes of visual field (checking), repetitive stereotyped behavior of a vari-

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TABLE 1
d-Amphetamine-Induced Changes in Behavior of Four Macaques

Type of Behavior	Behavior Score Expressed as Means ± SEM*			
	Clancy	Freda	Beckie	Suzie
Activity				
Baseline	7.75 ± 1.14	8.75 ± 1.75	8.00 ± 1.22	8.00 ± 1.22
Days 1–4	11.67 ± 0.27**	11.67 ± 0.27**	11.50 ± 0.43	9.00 ± 0.35
Days 5–8	11.00 ± 0.50	12.00 ± 0.00	—	—
Days 9–12	12.00 ± 0.00	12.00 ± 0.00	—	—
Stereotypies				
Days 1–4				
Social	12.00 ± 0.00**	0.00 ± 0.00**	0.30 ± 0.20	1.50 ± 0.80
Solitary	0.00 ± 0.00**	7.30 ± 2.60**	9.00 ± 1.80	0.50 ± 0.30
Days 5–8				
Social	6.30 ± 1.70	0.00 ± 0.00	—	—
Solitary	1.00 ± 0.60	9.20 ± 1.00	—	—
Days 9–12				
Social	0.00 ± 0.00	0.00 ± 0.00	—	—
Solitary	6.50 ± 1.20	8.30 ± 2.40	—	—
Checking				
Baseline	14.25 ± 2.43	11.75 ± 1.39	25.00 ± 1.46	18.75 ± 0.96
Days 1–4	168.67 ± 31.27**	37.67 ± 2.60**	29.75 ± 11.58	47.00 ± 4.11
Days 5–8	94.00 ± 16.09	20.25 ± 3.49	—	—
Days 9–12	31.25 ± 6.00	14.50 ± 3.36	—	—

*The number of intervals during which activity and stereotypies were present daily and the total number of checks within each of the intervals were averaged for 4 days of baseline, days 1–4, days 5–8, and days 9–12 of d-amphetamine treatment and expressed as mean ± SEM for each animal.
**Days 1–3.

ety of types (stereotypies), and progressive social isolation.

Changes in activity. Periods of rest alternating with periods of activity characterize normal colony life for each of the animals studied. Administration of d-amphetamine interrupted this cycle by inducing a chronically active state. Animals receiving the drug would seldom be without movement, except for checking, for 30-second intervals. Table 1 shows the increase in intervals of activity for each of four animals given d-amphetamine.

Stereotypies. Each animal demonstrated d-amphetamine-induced stereotyped behaviors. These were manifest in a variety of forms: threatening, lipsmacking, social grooming, presenting, self-grooming, scratching, and rocking. Table 1 shows intervals of stereotyped behavior per 12 intervals observed daily for four animals, two of which were given the drug chronically for 4 days and two of which were given it for 12 days. When stereotyped behaviors are divided into social stereotypies and solitary stereotypies[1] it becomes evident that even when social stereotypies are present initially, solitary stereotypies eventually dominate during the course of chronic d-amphetamine administration. (See the figures given for Clancy in table 1.)

Checking. Among the most striking behaviors seen in the animals given d-amphetamine was the marked increase in checking (shifting of visual field). Although this phenomenon was more marked in some animals than in others, like stereotypies it appeared consistently in all animals treated with d-amphetamine. Table 1 shows the marked increase in checking from baseline levels, especially in Clancy. There was a gradual subsequent diminution of this behavior during days 5 to 8 and days 9 to 12.

Social isolation. Social isolation has already been demonstrated in the development of nonsocial stereotypies that replace usual interactions such as social grooming and other initiated social activities. In each animal social grooming was reduced during the first days and continued reduced throughout the course of d-amphetamine administration (12 days for Clancy and Freda, 5 days for Beckie and Suzie). Initiated social activity varied considerably during the first 3 days of d-amphetamine administration because of social stereotypies but was reduced beginning with administration day 4 until the end of d-amphetamine administration. Similarly, proximity scores varied early in this part of the study but showed rather consistent reduction beginning on day 5 until the end of d-amphetamine administration.

The reduction in social operations and the reduction in proximity scores during d-amphetamine treatment were as follows: Clancy showed only 5 percent of her baseline social grooming during days 1 to 3 and 5 to 12, 45 percent of her baseline-initiated social activity during days 5 to 12, and only 50 percent of her baseline proximity score during days 5 to 12; Freda showed 37 percent of her baseline social grooming during days 1 to 3 and 5 to 12, 39 percent of her baseline-initiated social activity during days 5 to 12, and 47 percent of her baseline proximity

[1]Rocking, a fragment of threat behavior, was considered a social stereotypy; this is further explained later in the paper under the heading "Discussion."

scores during days 5 to 12; Becky showed no social grooming during days 1 to 5 and 80 percent of her baseline-initiated social activity during days 4 and 5; and Suzie showed 32 percent of her baseline social grooming during days 1 to 5 and 35 percent of her baseline-initiated social activity during days 4 and 5.

Reproducibility

The basic elements of the d-amphetamine syndrome were found to be reproducible, but they were often less exaggerated when the same animal was reintroduced to the drug. Table 2 shows the means for activity, stereotypies, and checking for Clancy and Freda during two subsequent 3-day trials of d-amphetamine compared with these means at initial baseline and during the previous d-amphetamine administration.

Pharmacological Dissection

Alpha-methyl-para-tyrosine (AMPT). The means for the 3 final days of AMPT pretreatment, the first 3 days of combined AMPT and d-amphetamine, and the first 3 days of d-amphetamine alone on two separate subsequent occasions are shown in figure 1 for activity, checking, and stereotypies in two animals. The increase induced by d-amphetamine in each of the measurements was prevented or greatly diminished by pretreatment and concomitant treatment with AMPT.

Chlorpromazine (CPZ). Pretreatment and concomitant treatment with CPZ also prevented the d-amphetamine-induced behaviors that appeared during subsequent trials with d-amphetamine alone (see figure 1).

Pimozide (PZ). In contrast to AMPT and CPZ, pretreatment and concomitant treatment with PZ permitted d-amphetamine-induced elevation in checking. Like AMPT and CPZ, it inhibited d-amphetamine-induced elevation of activity and stereotypies (see figure 1).

Reversal of Broader Aspects of the Syndrome

After pretreatment with 0.14 mg/kg of haloperidol a day for 21 days, two animals were given d-amphetamine along with a gradual increase in haloperidol in an attempt to block the effects of d-amphetamine on both social and solitary behaviors. At low doses of haloperidol the characteristic d-amphetamine-induced syndrome appeared. Haloperidol was increased stepwise until days 17 to 20 of chronic d-amphetamine administration. At this time the dose of haloperidol was raised to 0.57 mg/kg a day and most of the behavioral measurements, both social and solitary, returned to or near baseline levels. Table 3 shows the "normalization" of the syndrome by haloperidol 17 to 20 days after initiation of d-amphetamine by comparing behavioral measurements during baseline, during both early and late periods of d-amphetamine administration alone, and during combined d-amphetamine and haloperidol administration late in the d-amphetamine period. d-Amphetamine-induced checking was not reversed by haloperidol.

TABLE 2
Reproducibility of d-Amphetamine-Induced Changes in Behavior of Two Macaques

Type of Behavior	Behavior Score Expressed as Means ± SEM*	
	Clancy	Freda
Activity		
Baseline	9.0 ± 0.5	8.7 ± 2.3
Initial d-amphetamine administration	11.7 ± 0.3	11.7 ± 0.3
Repeat d-amphetamine administration	11.7 ± 0.2	10.8 ± 0.9
Stereotypies		
Baseline	0.0 ± 0.0	0.0 ± 0.0
Initial d-amphetamine administration	12.0 ± 0.0	7.3 ± 2.6
Repeat d-amphetamine administration	3.5 ± 1.0	8.7 ± 1.2
Checking		
Baseline	12.3 ± 2.4	11.0 ± 1.6
Initial d-amphetamine administration	168.7 ± 31.3	37.7 ± 2.6
Repeat d-amphetamine administration	71.2 ± 15.8	54.0 ± 16.2

*These values show scores during the final 3 days of baseline, first 3 days of d-amphetamine administration, and the mean of the subsequent two trials with d-amphetamine alone on days 1–3 expressed as mean ± SEM for each 3-day period for each animal.

DISCUSSION

Interest in developing model psychoses displaying similarities to naturally occurring psychiatric syndromes has accelerated in the past several years (3–8). In this study we have documented the induction of psychotic-like behavior by chronic d-amphetamine administration. Our behavioral measurements (as well as demonstration films) give evidence of a frantically hyperactive and agitated state, with hypervigilance diminishing with the development of increasing social isolation and solitary stereotypies.

The attempt to move from qualitative and quantitative observations of behavior to generalizations concerning similarities of d-amphetamine-induced behavioral alterations in nonhuman primates and psychopathophysiology of the schizophrenias is fraught with difficulties. However, this effort must be made if a link is to be suggested between a state so induced in nonhuman primates and psychiatric illness.

Bleuler's Classification

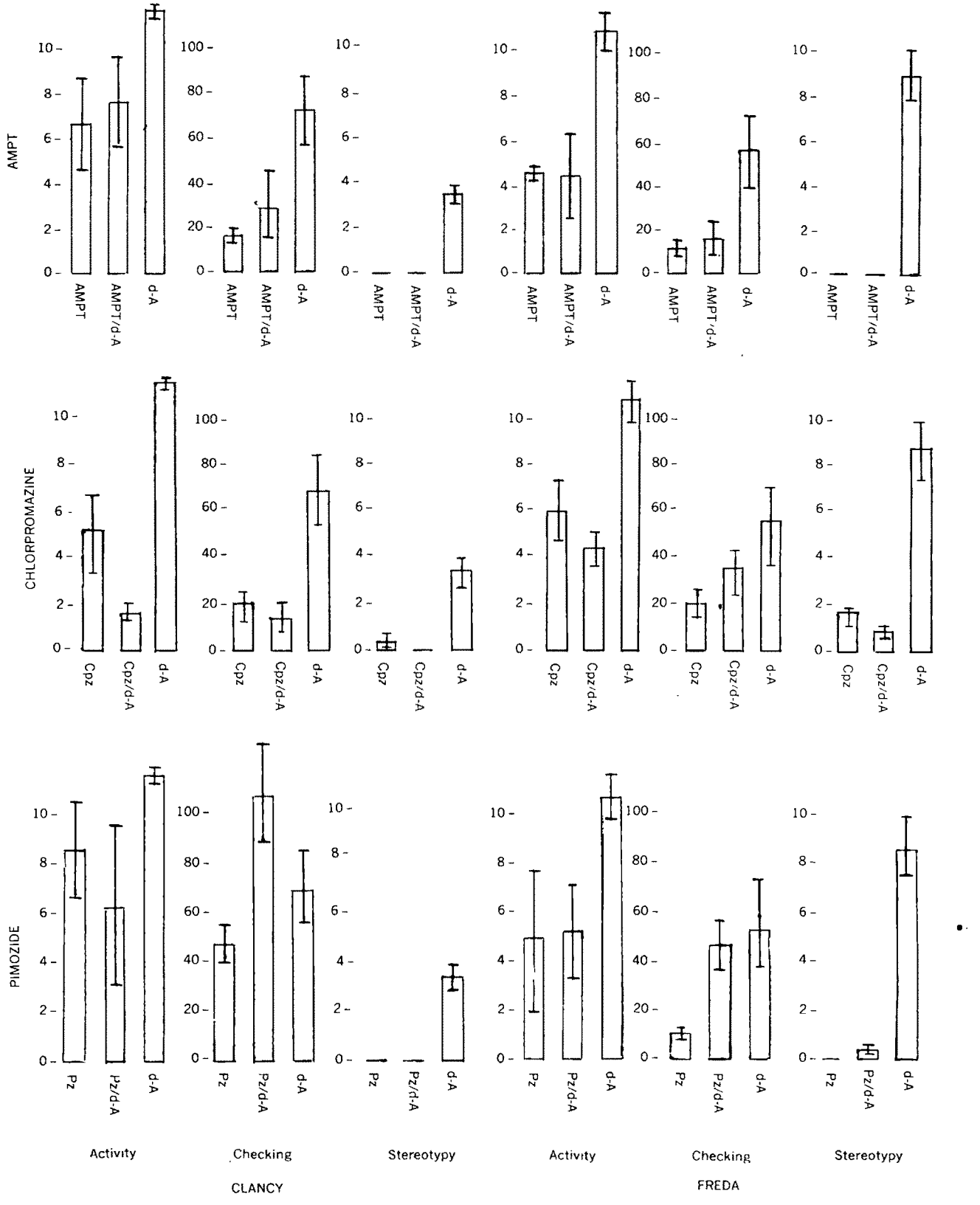
Using Bleuler's four A's (autism, associations, affect, and ambivalence) (9), it is possible to group many of the d-amphetamine-induced or altered behaviors as possible manifestations of these states.

Autism is suggested by the progressive social isolation demonstrated by proximity scores, elevated levels of self-grooming as compared to social grooming, inability to attend another animal's social signals, and preoccupation with the performance of solitary stereotyped behaviors to the exclusion of normal social interactions.

Affective inappropriateness is suggested by the excessive threats that appeared in dominant animals when no discernible stimulus of implied threat arose from other animals. The inappropriateness of stereotyped threat-

FIGURE 1

*Mean Behavior Scores (±SEM) During Administration of d-Amphetamine (d-A) with Alpha-methyl-para-tyrosine (AMPT), Chlorpromazine (CPZ), and Pimozide (PZ) in Two Macaques**



*These values are for the following time periods: during the last 3 days on AMPT alone, first 3 days of concomitant AMPT and d-A, and the mean of two subsequent trials (days 1-3) of d-A alone; during comparable 3-day periods with CPZ and d-A; and during comparable 3-day periods with PZ and d-A.

TABLE 3
Comparison of Effects of d-Amphetamine Alone with d-Amphetamine and Haloperidol Combined on Behavior in Two Macaques

Type of Behavior	Behavior Scores Expressed as Means ± SEM*			
	Baseline	d-Amphetamine Alone		d-Amphetamine and Haloperidol
		Days 1–3	Days 9–12	
Reversed behavior				
Activity	8.4 ± 0.6	11.7 ± 0.3	12.0 ± 0.0	9.6 ± 0.9
Sterotypies	0.0 ± 0.0	9.7 ± 1.6	7.4 ± 1.4	0.0 ± 0.0
Social grooming	11.8 ± 2.1	5.7 ± 3.2	1.4 ± 1.3	15.1 ± 1.9
Initiated social activity	14.3 ± 2.4	63.8 ± 30.5	5.5 ± 1.8	16.8 ± 1.8
Proximity	9.8 ± 0.7	9.3 ± 1.1	5.5 ± 0.9	11.0 ± 0.6
Threatening	0.5 ± 0.4	45.7 ± 27.6	0.6 ± 0.47	0.8 ± 0.6
Self-grooming	1.5 ± 0.8	3.8 ± 2.0	9.6 ± 1.0	0.6 ± 0.3
Behavior not reversed				
Checking	13.0 ± 1.5	103.2 ± 31.0	22.9 ± 4.5	37.4 ± 11.2

*The values show the effects of the drugs during 4 days of baseline, 3 days early in d-amphetamine administration (days 1–3), 4 days later in d-amphetamine administration (days 9–12), and 4 days of combined d-amphetamine and haloperidol (0.57 mg/kg a day) late in d-amphetamine administration (days 17–20).

ening was apparent to the animals not given d-amphetamine. These animals failed to respond submissively, suggesting that the behavior of the animals given the drug may have lacked the appropriate affective tone for meaningful social intercourse.

Ambivalence may be demonstrated by threatening without a follow-through attack when the animal threatened does not respond with a submissive gesture. It is also suggested by the appearance of the further fragmented threat seen in stereotyped rocking. This behavior appeared only during the time of hypervigilance, soon after stereotyped threatening (forward rocking, eyes open, brow raised, ears back). We suggest that fragments of behavior patterns, in this case the beginning of a threat sequence, may also be a behavioral manifestation of ambivalence. Ambivalence was also suggested by the short-lived, interrupted social interactions such as grooming.

The presence of abnormalities of associations (formal thought disorder) cannot be documented in animals who have no spoken language. Yet patterns of behavior, a relatively consistent behavioral language, can be grasped by the experienced observer. A fragmentation of sequenced behavior, though difficult to quantitate, is experienced by the observer dysjunctively. Animals not given d-amphetamine infrequently approached and often actually distanced themselves from animals given the drug. This avoidance may have been the result of fragmented and unintelligible social cues. It is this fragmentation of previously patterned sequenced behavior, without apparent relationship to events, which may be a nonhuman primate behavioral counterpart to the unintelligible cognitive stream seen in schizophrenias clinically.

The focus of activity on the self (solitary stereotypies) rather than on outside events and relationships within the colony would appear to be correlated with relief from the hypervigilant state demonstrated by a reduction in checking. This "autistic" withdrawal might have been necessary for homeostasis in the animals given d-amphetamine and may have implications for clinical schizophrenias.

Dopamine-Mediated Theory of Psychosis

With the administration of AMPT, the d-amphetamine-induced changes in activity, checking, and the appearance of stereotypies were blocked, indicating that these elements of the syndrome are catecholaminergically mediated. Chlorpromazine also abolished the d-amphetamine-induced behaviors. In contrast, pimozide prevented the hyperactivity and stereotypies but not the hypervigilant (checking) state. Since AMPT inhibits tyrosine hydroxylase, chlorpromazine blocks dopamine and norepinephrine receptors, and pimozide blocks primarily dopamine receptors (10, 11), these data are consistent with the view that d-amphetamine induces hyperactivity and stereotypies by means of dopamine systems. It also appears that the hypervigilant state may be produced by effects on norepinephrine systems.

When we attempted to titrate haloperidol, a preferential dopamine receptor blocker (10), against the d-amphetamine-induced syndrome, we were able to achieve a remarkable "normalization" of both social and individual behaviors in the absence of fully reversing hypervigilance. This reversal of psychotic-like behaviors by haloperidol is consistent with the hypothesis that dopaminergic systems mediate the isolated, withdrawn, fragmented, and inappropriate behaviors (other than hypervigilance) induced by d-amphetamine.

A dopamine-mediated theory of psychosis or schizophrenia by no means requires that large quantities of dopamine are released from dopaminergic terminals and are present on or near dopamine receptors within the central nervous system. At least two other possibilities exist. One involves such supersensitivity of dopamine receptors that they are activated too frequently by normal or subnormal amounts of dopamine and are "normalized" by an antipsychotic drug (a dopamine-receptor blocking agent).

A second possibility involves a critical balance between

two or more neurotransmitter systems, one of which is dopamine. Anticholinergic agents alone have been described as producing motor behavior reminiscent of that seen after small doses of amphetamine (12). If there were a deficiency in acetylcholine or other critical neurotransmitter systems supplying critical areas of the central nervous system that are physiologically balanced by dopamine, critical balance could fall to dopamine predominance. This would elicit a dopamine-mediated psychotic syndrome without excessive dopamine being present at dopamine receptors, yet relieved by blocking with antipsychotic agents the activation of the dopamine receptor.

Investigations concerning neurotransmitter mediation in animal models of psychosis show promise for defining possible defects in neurotransmitter systems. Such definition would focus clinical research strategies and verify impressions gained clinically.

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APPENDIX 1
Behavioral Scoring

Each animal in rotation was scored during a 30-second interval with regard to 15 social and 13 solitary behaviors, for a total of 12 such intervals for each animal during each daily scoring period. Social behaviors could receive additional scores when they took place with another animal during its 30-second scoring period (i.e., an approach by animal A to animal B during animal B's 30-second interval would be scored both for approach A to B and for being approached B by A).

An animal received a score for each occurrence of approaching, being approached, threatening, lipsmacking, withdrawing, scratching, or checking during a scored 30-second interval.

A single score was tabulated if social grooming, proximity, self-grooming, activity, or stereotypies occurred during a scored 30-second interval.

Scores were summed for each of the measurements for each animal for each daily scoring period. The initiated activity score is the sum of approaching, social presenting, submissive presenting, social exploration, social grooming, threatening, mounting, attacking, withdrawing, and lipsmacking for each daily scoring period.

Psychiatric Controversy: Man's Ethical Dimension

BY SILVANO ARIETI, M.D.

Although determinism may permeate human existence, man's moral values raise him above the level of an animal and enable him to direct his own life. The author suggests that psychiatrists should influence the patient to exert his will, make conscious choices, and, above all, assume a sense of responsibility for his own actions. In order to free the patient from whatever conditions hinder his will and to help him make choices, psychiatric treatment must consider man's ethical dimension.

COMMITTED AS WE ARE to the scientific method, we psychiatrists divide, dissect, and examine the psyche of the human being piece by piece. This is a legitimate procedure, provided that after the analysis we reach a synthesis, give the proper consideration to those aspects of the personality that could not expand, and, most important, do not leave out any basic human dimension.

We do not always follow this procedure. In our double allegiance to science and to man, who in his totality is not reducible to the accepted canons of science, we tend to adhere to traditional science exclusively and to minimize man's ethical dimension. In what I call the "ethical dimension" I include such vast areas as moral values and the phenomena of will, conscious choice, and responsibility.

I do not mean to suggest that the therapist should impose his values on the patient; I simply wish to stress that values always accompany and give a special psychological significance to facts and that when we deprive facts of their value, we fabricate artifacts which have no reality in human psychology. An individual may suspend his value judgment when he wants to examine a fact from a specific point of view, but then the ethical content has to be reestablished if the fact is to have human significance. If we remove the ethical dimension, we reduce man to a subhuman animal, an animal that is not *beyond* freedom and dignity, but whose organization *precedes* the experience of freedom and dignity—a subhuman animal to whom Skinnerian psychology can be safely applied.

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It is easy for many of us who practice psychodynamic psychiatry to understand how Skinner's approach has only limited application to our work. The functions of the psyche that we study in our daily work—feelings, emotions, attitudes, introjection, guilt, expectation, purpose, goal, inner self, personality, determination, choice, will, etc.—are miraculous or imaginary entities for Skinner (1). According to Skinner, ideas, dreams, images, insights, and conflicts cannot be seen or observed and, therefore, do not count, nor can the existence of an inner life be inferred from them. Skinner follows a procedure antithetical to the medical procedure, for a physician does not simply observe his patient's behavior but also makes inquiries about what goes on inside of the patient.

Although I have never gathered statistics on a large scale on this subject, I am inclined to believe that many psychiatrists are ready to reject Skinner's position. But unfortunately, many of us are willing to accept other positions that do not consider adequately the ethical dimension. In contrast to the position of Rollo May (2), Leon Salzman (3), Leslie Farber (4), myself (5), and many others, a large group of psychiatrists and psychologists do not believe that there is such a thing as human will. Certainly a normal voluntary action consists of many steps, some of which are not yet susceptible to scientific analysis. We do not know when neurology ends and psychology begins. We do not know the intimate neurological mechanism that initiates a voluntary movement. Perhaps what we call will is the synthesis or result of many neuropsychological mechanisms plus newly emerging elements that in a tentative way we call autonomy, individuality, originality, creativity, and indeterminacy.

PREEMINENCE OF DETERMINISM

Determinism reigned supreme in the era of hard-to-imagine proportions that extended from the appearance of the atom to the development of the human cortex. The simplest entities (the subatomic particles) and the highest (some parts of the human cortex), respectively, opened and closed this vast era that unfolded over billions and billions of years. The most complex entity in our universe, the human cortex, again permits a certain independence from causality as it existed at the subatomic level studied by Heisenberg. However, the freedom of man,

made possible by his cortex, is different from the so-called freedom of the subatomic particles. It is integrated with the essence of man. Although this freedom produces an interruption in the deterministic chain of causes and effects, it immediately rejoins determinism, thereby re-establishing continuity, for the will of man becomes a *cause* of action. It is a causality compatible with free will. It is for future research to establish whether subatomic "freedom" becomes incorporated in some particles of neurons and changes ideas into free actions and thus reintegrates itself into the essence of man.

For many psychiatrists, including myself, what we call will, that ability by virtue of which we conform our behavior to our determination, is the culmination of the psychological functions of the human being. Certainly we can bypass our will. We may meekly obey others, or we may behave in conformity with our conditioned reflexes. If we have some psychiatric disorder, our will is hindered in various ways. If we are hysterical, we lose control of some functions of our body. If we are phobic, the avoidance of the dreaded event rather than our determination will guide our actions. If we are obsessive-compulsive, we feel obligated to obey internal injunctions even when they seem absurd. If we are psychopathic, we cannot say no to ourselves; we are under the impulse to satisfy our urges immediately. If we are catatonic, we go through a stage in which even our smallest movement may be endowed with cosmic responsibility and guilt; consequently, we do not move at all. Those of us who have intensely studied the catatonic type of schizophrenia consider the catatonic state to be the nadir of the human condition (6). Although the catatonic is not physiologically paralyzed, he cannot respond to people who touch him, bump into him, smile at him, or caress him. He appears to be a statue, but unlike a statue he hurts in a most atrocious way, having lost the most precious and human of his possessions —his will. By studying cases of catatonic schizophrenia of different degrees of severity, we can learn a great deal about the existence, unfolding, and impairment of the will (6).

Psychiatric treatment attempts to liberate the patient from whatever condition limits his will, whether it is a mild neurosis or a severe catatonia. It should be understood, however, that total freedom and total self-causation are not available to any man. Even partial freedom is not something a human being is born with; it is a striving, a purpose—something to be attained. Being born free is a legal concept that, although valid in daily life, has philosophical limitations. Striving for freedom is an unceasing attempt to overcome the conditions of physicochemistry, biology, psychology, and society that affect human life. The psychiatric patient has the additional burden of overcoming the conditions of his psychopathology, and the purpose of psychiatric treatment is to help him do so. It would be unrealistic to forget, however, that this self-causation is only a thin margin of a totality in which the majority of facts and events are ruled deterministically. But I feel that this thin margin is sufficient to change the world, to make history, to cause the rise or fall of man (5).

FREUDIAN VIEW OF THE CONCEPT OF WILL

Classical Freudian psychoanalysis has a controversial (and I would say ambivalent) attitude toward the concept of will. On one side, Freudian psychoanalysis adheres to a strict deterministic view of reality and life that leaves no room for human choice. According to Freud, most of our actions are caused by unconscious motivation, and as long as our actions are the result of unconscious motivations, we cannot call ourselves free or feel responsible for what we do.

Like many other great thinkers, Freud contradicted himself on many issues, including the question of will. More than any of his predecessors or contemporaries he revealed the role of the unconscious wish as a determinant of human behavior. But Freud's great discovery does not imply that will has no role. Let us consider Freud's famous statement, "Where id was, ego must be." Freud meant that as a result of psychoanalysis, unconscious wishes, generally relegated to the id, must become part of the ego; i.e., they must become conscious. But what is the purpose of this? To make the id part of the ego does not mean unleashing the unconscious wishes or giving them free reign or unrestricted access to conscious behavior, although this is the way some people interpret Freud's statement. I believe that Freud meant that once the unconscious wishes become conscious, they will be regulated by the functions of the ego. The individual will be in a better position to accept or reject them. In other words, Freud conceived psychoanalysis not as a liberation of the id but as a liberation of the ego from the unwanted, unconsciously determined oppression exerted by the id. Thus, psychoanalysis has the function not of restricting but of enlarging the sphere of influence of the will. Its aim is to return a sense of responsibility to the human being for many actions that previously were beyond his control. In this respect, psychoanalysis enlarges the ethical dimension.

POSITION OF SOME PSYCHODYNAMIC SCHOOLS

In addition to Freudian psychoanalysis, some schools of psychodynamic psychiatry have also neglected the role of autonomy and individuality, which are prerequisites for free will. Whereas some geneticists believe that most or all of our life is predetermined by our genetic code, some psychodynamic psychiatrists believe that our present life is entirely determined by our past experiences—by what our parents, families, schools, and society have done to us. Thus, although the psychiatrists who focus only on the environment do not invoke heredity, their basic philosophy is similar to that of the geneticists: man's destiny is shaped by forces external to the self.

WE CREATE OUR OWN SELF-IMAGE

Obviously we are influenced by external forces. Genetic, familial, and social factors are important, but not to the extreme degree that many psychiatric studies im-

ply. Conceptions that view the individual only as a passive agent or tabula rasa, as a receiver, or as a puppet pulled by strings of different kinds have prevailed in daily psychiatric practice. For instance, when we elicit a history from the patient's family or (in most cases) from the patient himself, our aim is to establish how this history has made the patient what he is now. Some psychiatrists ignore completely the fact that the patient has always recreated that history. What he tells us is seldom what happened but more frequently what he perceived and interpreted, what he assimilated, and what his memory has constantly changed and given different meaning to. The child does not just reflect or absorb from the environment; he also tries to select what to absorb or what to give prominence to. The image that the child has of himself does not consist of reflected appraisals from parents or family members but of what the child did with those appraisals. In the same way, the image that he has of his parents and siblings, although related to the actual essences of these people, is not a mirror reproduction but rather a subjective interpretation. There is a definite discrepancy between the way reality and the significant people in one's life were in the past and the way one has perceived them. This discrepancy is particularly pronounced in the schizophrenic and preschizophrenic individual but also exists (to a lesser degree) in the neurotic individual and in all of us. This discrepancy is one manifestation of individuality. The image that the individual has of himself is particularly important because it is a major constituent of inner life or what is at times called the self. And, our self-image is not created exclusively by others but also by ourselves. We are among our own creative forces.

I must stress again that I do not mean that we are completely free. The self in whose creation we have cooperated is also the result of our specific biological endowment and a random mixture of external factors. The psychiatric patient has less possibility of contributing to the creation of his own self than the normal person because he was handicapped by external contingencies. However, the patient who has successfully progressed to an advanced stage of treatment will stop blaming his mother or father, his childhood, his spouse, or the conditions at work for all his troubles. The more he becomes conscious of his secret life (the more he understands his thoughts and motivation), the more he increases the area of his responsibility. He recognizes the role that other people played in his life, but he assumes some responsibility for what happened to him and especially for the way he will direct his life in the future. Of course, it would be absurd for him to think that his destiny will be entirely in his own hands, but he is aware that he too is a determining force in his own life.

Insofar as psychiatric treatment increases the ability to make choices, it is constantly involved with man's ethical dimension. Any choice that affects others reveals our sense of responsibility, our concern or lack thereof not only for ourselves but for others. What we are responsible for is typically a product of our own self. Of course, when responsibility becomes one's only concern, it is distorted and assumes a tyrannical role; however, its absence, or a great decrease in it, produces in us the psychopathic variety of human life.

SELF-REALIZATION AND THE ROLE OF PSYCHIATRIC TREATMENT

A misinterpretation and a misapplication of some psychiatric and psychoanalytic concepts stand out among the many causes of the permissiveness and hedonism of our days. I refer particularly to the concept of self-realization that has persuaded many to strive for self-fulfillment, even if this means disregarding the rights of others. This misunderstanding derives not only from the already mentioned concept of id liberation, misconstrued from Freudian theory, but also from a broad generalization of some concepts of the neo-Freudian schools of psychoanalysis and humanistic psychology. Maslow, Horney, and Fromm believe that the highest ethic, as well as the aim of psychotherapy, is the one that leads to self-realization.

This point of view is controversial on many grounds. First, there is no preordained, specifiable potential in man that has to be realized. Man is indefinite and capable of unpredictable growth because of the multitude of possible encounters with different systems of symbols and concepts (7). Man must aim at continuous growth or self-expansion, but not at a mythical realization of an assumed potential. Man is not an acorn that may become an oak. For man, there is no question of potentiality but of infinite possibilities. Second, "self-realization" is very deceptive as a subjective experience. Reading the writings of Mussolini and Hitler, and even of some politicians of our own times, one is forced to conclude that these people were sure of realizing themselves and their "own destiny" by following a mission or mandate given them by the people. Third, and most important, self-realization ignores the actual problem of ethics, one's moral relation to others. Self-fulfillment is not necessarily an ethical aim; it may be a form of hedonism and narcissism, again easily recognized in the lives of some politicians. What some authors mean by self-fulfillment is a legitimate aspiration. However, when self-fulfillment is pursued, it is not on ethical grounds but for personal gratification. To remain ethically justifiable, it must not interfere with ethical principles. We certainly should aspire to our psychological growth and happiness, provided we do not infringe upon the rights of others.

Ultimately, we must ask the question of whether psychiatric treatment itself conditions the patient by making him choose accepted behavior and reject what is considered socially unacceptable behavior. To the extent that treatment has this effect, it is not psychodynamic; it does not enlarge the freedom of man. We must be able to make a fine distinction. Influencing the patient (as psychodynamic treatment does) does not mean conditioning the patient; it means increasing the patient's vistas and his range of choices. The patient then does the

choosing. As a matter of fact, as Halleck (8) has recently stated, the patient should have a voice even in the choice of his own treatment.

CONCLUSIONS

Often a defeatist philosophy of life, in which everything is presumed to be fallacious or illusionary, permeates psychotherapy. According to this view there is no escape from the determinism that regulates human life (9); human life is a part of a deterministic cosmos in which everything is caused by something else. Obviously a large part of our existence is determined by outside forces. Certainly we must agree with Freud that the part of the iceberg which is submerged is much larger than that above the surface. But from that part which is above water we can see the polar star and a large part of the firmament. Even though the deterministic forces prevail and ultimately overcome us, we should not feel defeated if we have added our will, our choice, and our sense of responsibility to the conditions that give meaning and direction to our existence.

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Private Psychiatry and Accountability: A Response to the APA Task Force Report on Private Practice

BY STEVEN S. SHARFSTEIN, M.D., M.P.A., CARL A. TAUBE, AND IRVING D. GOLDBERG, M.P.H.

The authors note that the imminence of national health insurance makes it very important to determine the roles, efficiency, and effectiveness of both the private and the public sectors of mental health care. The difficulties in distinguishing public from private care are examined. The authors present estimated distributions of care by type of provider that differ from those of an APA task force report on private practice. They point out the need for objective research on the quality of care in both sectors and on the effectiveness of alternative mental health systems, suggesting that public choices should be made on the basis of correct interpretations of reliable data and accountability to those being served.

AS NATIONAL HEALTH INSURANCE coverage for mental illness is debated in the coming months, one of the issues will be the role private psychiatry will play in the final plan. The future and structure of mental health services in this country will hinge on the benefit package provided by the plan. A balanced assessment of the current contribution of private practitioners is necessary in order for the public to be served with quality care at reasonable cost.

The American Psychiatric Association's task force report, *The Present and Future Importance of Patterns of Private Psychiatric Practice in the Delivery of Mental Health Services* (1), is one attempt to assess "the vital role of its private practitioner members in the delivery of mental health services to the American people" (p. v). The report makes several statements regarding the superiority of the private practice delivery system, including the following:

> It seems doubtful that there is any health service rendered by a public facility that could not be as, or more, effectively rendered by the private sector of psychiatry from the standpoint of quality and economy. . . . To the extent public facilities can integrate the private sector of psychiatry under contractual or fee-for-service arrangements, the public will be better served and at the same or possibly a lower cost. (pp. 20, 21)

These conclusions have elicited comments that challenge the quality and economy of organized patterns of care and public policies favoring organized care settings such as community mental health centers (2).

In this paper we will take issue with some of the task force's data and their interpretations of the data. We will also deal with issues related to the distinction between public and private care and to accountability, quality assessment, and economic factors. These issues are necessary components in any comparative analysis of the organization of mental health delivery systems, and they must be faced before public policy regarding national health insurance can proceed in a rational and responsible manner.

DATA ON THE RELATIVE ROLE OF THE PRIVATE SECTOR

The task force report presents an analysis of the contributions of psychiatrists in private practice to the delivery of mental health services. Their analysis was based on a study that was conducted in the state of Kentucky in 1970 (3). From these data, the report concludes that

> The private practice segment of the profession in Kentucky is the largest component of the state's mental health delivery system. This finding quite possibly may be applicable to the nation as a whole. (1, p. 15)

The report later states with more certainty,

> All in all, it seems fair to estimate, as the Kentucky survey suggests, that roughly half of about 5,000,000 persons who seek, each year, psychiatric care in the United States seek and receive it from private practitioners. (1, p. 19)

Finally, near the end of the report, all uncertainty about the relative role of the private practitioner seems to have disappeared, and we find the statement,

> It is useful to picture the private practice sector of psychiatry as a massive national outpatient and inpatient service for the mentally ill, and one that meets the service needs of about half of all emotionally disturbed persons who seek professional help. (1, p. 27)

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Aside from the statistical hazards inherent in projecting findings from a single state to the nation as a whole, other data on the mental health system that were not examined in the report seem to indicate that more modest claims regarding the role of the private practice sector of psychiatry might be more appropriate, even in the state of Kentucky. An examination of some of these data follows.

Kentucky Data

The most recent year for which the Kentucky Department of Mental Health has published data is 1972; these data relate to state mental hospitals and community mental health centers (4). In order to compare these figures with those for private practice, we will accept for the moment the 1970 survey (3) estimate of 12,300 individuals under the care of private practitioners in Kentucky and assume for the purposes of illustration that this number increased by 25 percent between 1970 and 1972 (to 15,375). This provides us with the following picture: Of the total number of individuals under psychiatric care in Kentucky in 1972 (N=66,254), 23 percent (N=15,375) were served by private practitioners, 12 percent (N=7,948) by state mental hospitals, and 65 percent (N=42,921) by community mental health centers (CMHCs).

These data seem to indicate that private practice accounts for a quarter—not a half, as stated in the task force report—of the individuals served annually. This proportion is more consistent with the results of a study by Hornstra and Udell (5), who found (in a seven-county area which included Kansas City, Mo.) that 29 percent of all individuals applying for psychiatric services during a one-year period (1967–1968) were accounted for by the private sector and that 35 percent of all those under psychiatric care on a given day were accounted for by private psychiatrists. Also of interest in this regard are unpublished data from the psychiatric case register in Monroe County, N.Y. (6), which indicate that of all persons seen in psychiatric settings in that county in 1971, fewer than 20 percent were seen by psychiatrists in private office practice (even after adjustment for underreporting to the register), and about a third of those seen by the private practitioner were also seen in other psychiatric settings during that year.

National Estimates

Discussion of task force estimates. The task force calculates the number of persons served annually by private psychiatrists in the United States in the following manner:

1. According to a study by the American Medical Association (7), an average practitioner in psychiatry has 55 patient visits a week and works an average of 48 weeks a year (1, p. 16).

2. These figures were multiplied by an unreferenced figure of 8,000 psychiatrists in full-time private practice (8,000 × 48 × 55), yielding a figure of 21,120,000 visits annually to private psychiatrists (1, pp. 3, 18).

3. An unreferenced figure of 300 was used as the number of individuals seen annually per psychiatrist, which, multiplied by the number of psychiatrists (8,000), yields a figure of 2,400,000 individuals seen yearly by psychiatrists in private practice (1, p. 18).

We arrived at an estimated national distribution using the task force's figures and unpublished estimates of individuals seen in public and private facilities that we derived from National Institute of Mental Health (NIMH) data (8), adjusted for duplication.[1] Of a total of 5,753,000 persons receiving psychiatric care in 1971, 42 percent (N=2,400,000) were seen in private practice, 17 percent (N=972,000) in private facilities, and 41 percent (N=2,381,000) in public facilities. (These data are unduplicated within settings only.)

There are several factors that must be considered in interpreting these data. First, the counts for the private sector are not completely unduplicated. A certain proportion of the episodes in the private-practice category represent people who were admitted, during the course of their episode with the private psychiatrist, to a private mental health facility (e.g., private general hospital or private psychiatric hospital). Such people would also be counted among the episodes in private facilities, which inflates the total count of individuals in the private sector.[2]

A second problem concerns the validity of the task force estimate of 2.4 million persons under the care of psychiatrists in private practice. A critical issue in this estimate is the task force's figure of 300 different individuals under care annually per private psychiatrist.[3] Data from various surveys of psychiatrists that were not cited by the task force seem to indicate that 300 is a considerable overestimate (see table 1).

Modified national estimates. A rough estimate of the number of different patients seen annually by private psychiatrists may be obtained from the unweighted average of the results of the surveys summarized in table 1. If one rejects the data from California (15), where the practice of psychiatry is particularly atypical of the nation as a

[1]Facility data on episodes (i.e., the number of people under care at the beginning of a year plus all admission actions during that year) were converted to "individuals" by multiplying the episodes by 0.8, a factor derived from the Maryland Psychiatric Case Register, which indicated that persons in that register had an average of 1.2 episodes of care per year.

[2]An estimate of this overlap is provided by an NIMH study of discharges from general hospital psychiatric units (9) that indicated that 54 percent of the discharges from private general hospital psychiatric units were referred to a private psychiatrist. In addition, another study of private mental hospitals (10) indicated that the referral source to the hospital was a private psychiatrist in 45 percent of the cases. Using these proportions, it may be estimated that 216,000 of the 972,000 estimated episodes for private facilities were referred to or from a private psychiatrist. This number should be subtracted from the total of 3,372,000 persons listed for the private sector (private facilities plus private practitioners). The degree of overlap between the public and private sectors in patients treated is unknown, but probably small, and is therefore ignored for purposes of this discussion.

[3]One might also take issue with other estimates used or quoted in the report. For example, the report notes that the AMA study (7) referred to by the task force reported that the average number of hours spent weekly by psychiatrists in providing direct care was 37.3. An APA study (11), however, reported this average to be 31.5 hours—a substantial discrepancy.

TABLE 1
Number of Different Persons Seen Annually per Psychiatrist: Selected Surveys

Authors	Year Covered by Survey	Site	Number of Different Patients Seen per Year
Schulberg (12)	1963	Massachusetts	135
Bahn and associates (13)	1963–1964	United States	107
Klee and Warthen (14)	1965	Maryland	93*
Littlestone and Brown (15)	1966	California	259**

*The median was 32 for psychoanalysts. The figure for nonanalysts is used because it is more representative of private practice in general.
**Estimated from other data given in the study.

whole, the average is 112 individuals seen annually per psychiatrist. (If the California data are included, the average is 149—still only half the figure used in the task force report.) Using this average of 112 and eliminating the overlap of an estimated 216,000 patients seen in both private facilities and private office practice, the unduplicated count of persons seen in the public and private sectors may be estimated as follows: Of a total of 4,033,000 psychiatric patients in 1971, 41 percent (N=1,652,000) were seen in the private sector, and 59 percent (N=2,381,000) were seen in the public sector. (These figures are unduplicated within sector.)

However, this method of estimating the role of the private sector in the provision of mental health services is deficient because it does not take into account the volume and kinds of services given to each person. Table 2 presents the units of service generated annually by the public versus the private sector of psychiatry, based on unpublished NIMH data for 1971. Because inpatient and outpatient services are so different, they are treated separately. (Units of service in table 2 are allocated to the public or private sector according to the ownership of the facility.)

The task force estimated that private psychiatrists generate 21,120,000 visits annually. Presumably, this includes the estimated 6,210,000 visits in private mental health facilities shown in table 2. Private office practice visits exclusive of these visits would number 14,910,000. This estimate is almost three and a half times the figure given by the National Center for Health Statistics (NCHS), based on a national sample survey (16). Even if one assumes that the NCHS survey represents an underestimate of 50 percent (resulting from hesitancy about reporting psychiatric care in a household interview), the modified estimate would be only 6,560,000, as contrasted to the task force estimate of 14,910,000. If we use the modified NCHS estimate of office visits (rather than the task force estimate) and the other estimates for outpatient and inpatient services shown in table 2, we derive the volume of services for the private and public sectors that is summarized in table 3. We find, therefore, that when the volume of services is taken into account, the private sector accounts for a total of 53 percent of outpatient visits and 12 percent of inpatient days.

TABLE 2
Estimated Annual Volume of Inpatient and Outpatient Services in Public and Private Psychiatric Facilities for 1971

Type of Facility	Inpatient Days (in thousands)	Outpatient Visits (in thousands)
Public		
State and county mental hospitals	95,584	2,171
VA psychiatric hospitals	11,945	1,182
General hospital psychiatric units	2,178	1,219
Federally funded CMHCs	2,225	3,376
Outpatient clinics		3,206
Total	111,932	11,154
Percent	88%	64%
Private		
Mental hospitals	4,293	506
Residential treatment centers for emotionally disturbed children	6,378	—
General hospital psychiatric units	4,794	1,661
Outpatient clinics	—	4,043
Total	15,465	6,210
Percent	12%	36%

TABLE 3
Estimated Annual Volume of Inpatient and Outpatient Services in Public and Private Psychiatric Settings for 1971

Type of Setting	Inpatient Days		Outpatient Visits	
	Number (in thousands)	Percent	Number (in thousands)	Percent
Private office practice	—	—	6,560*	27
Private facilities	15,465	12	6,210	26
Public facilities	111,932	88	11,154	47
Total	127,397	100	23,924	100

*Private office practice visits are based on modified NCHS data (16) rather than the estimate used in the APA task force report (1).

The question remains as to how these different units of service should be combined to arrive at a weighted total. A reasonable approach would be to use a weighting based on the cost of a visit in relation to the cost of an inpatient day, which is analogous to the American Hospital Association's model for combining outpatient and inpatient services to arrive at "adjusted patient days" (17). On this basis, using the ratio of allowable benefits under the Blue Cross and Blue Shield health insurance program for federal employees, we may assume that three outpatient visits are equivalent to one inpatient day. Thus, dividing the outpatient visits by 3 and adding this to the number of inpatient days, we arrive at a weighted measure of service units. The public sector accounts for 85 percent (N=115,650,000) of these units and the private sector for 15 percent (N=19,722,000).

Need for more and different data. The vast difference in the relative role of private psychiatry, when put in terms of the volume of services as opposed to the number of different individuals seen, is readily apparent from these data. Examining the kinds of services provided by the public and private sectors is also important in evaluating their relative roles. For example, Miles and associates (18) found that 44 percent of the individuals seen by private psychiatrists were seen only for diagnosis.

Data are also lacking on the relative efficiencies and effectiveness of different mental health professionals. Social workers, clinical psychologists, psychiatric nurses, and others provide valuable services. Like psychiatrists, these professionals practice in a mix of public and private organized care settings and in private offices. The difficulties in measuring their roles relative to each other and to psychiatrists complicate the issue still further.

PRIVATE VERSUS PUBLIC CARE: FURTHER ISSUES

Distinguishing Between the Two Sectors

The distinction between private practice and public care is not as clear as the task force report implies. The loci and organization of psychiatric care are varied, and there is a complex mixture of public and private funding involved. Direct public support, third-party payments (including Medicare and Medicaid), and out-of-pocket funds all finance different costs of both public and private facilities.

Like psychiatric facilities, professional providers are not easily distinguished as public or private, since they often work in different care settings. Psychiatrists do not fall into mutually exclusive categories of those who are salaried and employed in organized psychiatric facilities, either public or private, and those who are engaged in private office practice. While certain psychiatrists do fall into only one or the other of these two groups, many others are both employed in a public organized setting and engaged in private practice. Furthermore, many psychiatrists who are not employed in an organized psychiatric setting use such settings for their patients' care through their staff privileges at a hospital or other facility.

The available national data are either utilization data on mental health facilities or data on the activities of psychiatrists as a group. Neither of these data sets enables one to clearly distinguish the boundaries of the private sector. For example, if a psychiatrist sees a patient in his private practice, admits the patient to the psychiatric unit of a city or county hospital, and continues to see the patient on an outpatient basis after his discharge from the hospital, should this patient's hospital stay be counted as private or public care? NIMH data on discharges from city or county general hospital psychiatric inpatient units (8–10) include such patients in the public category.

The task force estimates that private psychiatrists see over 2 million different individuals a year. It neglected to point out, however, that a certain proportion of these psychiatrists are salaried employees in public organized mental health settings and that their patients are therefore treated in the public care system.

The task force report does describe several private organized care systems (e.g., health maintenance organizations and group practices) as distinct from solo private practice. This distinction is a more useful one than a private/public dichotomy, as it separates different models of mental health care delivery. The efficacy and efficiency of solo versus group or organized care is not spelled out in the report and, despite the proper delineation of several of these organized care systems as private, one is left with the impression that the task force equated private practice with solo practice.

Accountability, Efficiency, and Costs

The most essential issues we must deal with involve the accountability and efficiency of private psychiatry. Accountability to the public for medical care is an increasingly significant issue as national health insurance becomes an imminent reality. It is not enough to say that higher quality and lower cost care can be delivered by a particular sector of the mental health service system. One must specify what populations are under care among the range of mental health problems. Will the professional providers agree to be accountable for unmet needs? Who will redistribute mental health resources? The CMHC catchment area concept is an attempt to operationalize this accountability issue. Will private care systems accept this concept? According to the task force report:

> To date the private sector has not demonstrated . . . its capacity to deal . . . with the full range of national mental health problems. . . . Among these areas of deficiency may be cited the following:
>
> 1. Failure to meet the needs of emotionally disturbed and mentally retarded children and adolescents and their families. . . .
> 2. Failure to meet the needs of the poor. . . .
> 3. Failure to meet the health needs of the chronically ill, including psychotics, the aged, and victims of organic brain syndromes. . . .
> 4. Failure to make any major impact on the treatment of hard drug addicts, alcoholics, mentally retarded, the delinquent and criminal population, and the "criminally insane." (1, pp. 20, 21)

If private practice allows the provider to declare almost unilaterally the conditions of his practice, especially in regard to whom he will and will not treat, then the accountability of a private care system seems to rest with the provider to the provider. The public care system, including public mental hospitals and CMHCs, has evolved because of the previously noted failure of the private sector to meet the needs of the groups mentioned by the task force. It is clear that private care systems have not included in the past those populations least able to afford or obtain care. To the extent that national health insurance will enable these groups to get care, it is incumbent on both the public and private care systems to develop accountable responses to their demands for care.

It is also essential that objective research designed to

assess the quality of care be stepped up and that requisite standards of care be established so that peer review can be more than a ratification of the status quo. The taxpaying public has the right to get the most from its dollar, and private care systems must open themselves for public review and comment.

The efficiency of alternative mental health delivery systems must be tested in a broad and objective manner. There is no uniform agreement at the present time on cost measures that can be compared from one delivery system to another. Cost of an episode of illness and cost per patient hour or "encounter" must be considered in relation to outcome. Similar services provided by different professionals—psychiatrists, psychologists, social workers, nurses, and the "new" professionals—must be compared. Cost studies must take differing patient populations into account, and the cost of team care must be weighed against the benefits. The savings that result in other sectors of the health and human service system from the utilization of mental health services must be estimated. Cost/benefit logic needs to be applied to indirect services such as consultation and education.

The task force asserts that the cost of care in the private sector is the same as that in the public sector. In support of this statement, the report cites three references. The first (19) contains no data relating to this subject—only the assertion by the authors that this is the case. The other two references (20, 21) include discussions of unit costs in public and private facilities and state that they are equivalent. It should be noted, however, that equal unit costs do not necessarily mean that the cost per episode of treatment is equal. One facility may be providing an average of 6 units at unit cost x while another facility is providing an average of 12 units at unit cost x to produce the same result. Many factors, including the nature of the populations and problems served, differences in outputs or results, and definitions of an episode of care, complicate the assessment of cost. The simplistic approach of the task force does not provide an answer to the question of the relative cost of private versus public care. While it may be that the private sector can provide care more efficiently than the public sector, data supporting this hypothesis are not currently available.

CONCLUSIONS

There are no clear data available to permit adequate assessment of or definitive conclusions about the current relative roles of the public and private sectors, however defined, in the provision of mental health services. Each has a significant role to play and, as the task force report indicates, a balanced mix of the two is essential. Therefore, it is premature at this time to assert the superiority of private care over public care. This issue is complex and requires thoughtful distinctions among public and private organized care systems and solo practice, with public choices being made on the basis of correct interpretations of reliable data and accountability to the people.

The issues we have discussed in this paper remain incompletely resolved. What is clear, however, is that patients need accessible services that are effective and efficient. Representatives of both the public and the private sector of psychiatry would agree that mental illness should not be granted a second-class status by national health insurance proposals and that the right to health includes the right to emotional well-being.

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The Clinical Research Ward as a Therapeutic Community: Incompatibilities

BY LOUIS H. REICH, M.D., AND BRIAN L. WEISS, M.D.

The authors discuss the numerous incompatibilities between the clinical research ward, with its emphasis on the collection of baseline and treatment data, and the therapeutic milieu environment, with its emphasis on an open door, team orientation, and nonauthoritarianism. They posit that the two orientations may be mutually destructive and that the therapeutic milieu may not be the best treatment setting for patients with schizophrenic or certain affective disorders. Two case histories illustrating these ideas are included.

THERE HAS BEEN a rapid proliferation of inpatient psychiatric research wards over the past decade, partly because of the growing emphasis on clinical psychobiological and psychosocial research in psychiatry. However, little has been written documenting practical problems such wards consistently encounter (1–3). In particular, the type of clinical setting within which the research is conducted may vitally affect the "success" of the research and thus of the ward. The current fad in psychiatric units has been the therapeutic milieu, established according to the principles of government by the patient community. For reasons of prestige (4) or other factors, this type of ward has become exceedingly popular.

This article is based on our experience in helping to establish a clinical research ward designed to operate as a therapeutic community. The primary purpose in organizing such a ward was to study psychobiological measurements, especially sleep, psychomotor activity, and circadian rhythms, in affective disorders and schizophrenia. We anticipated inevitable conflicts between research goals and therapeutic interests (1–3, 5); our practical experience now suggests that running a research ward in the form of a therapeutic community may be an attempt to create a partnership between antithetical concepts.

SETTING

The clinical research ward at the Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine, is a 26-bed inpatient unit that maintains hospitalized patients for an average period of six to eight weeks. Informal and written consent for participation in the research procedures is obtained from all patients and their families at the time of admission. Research procedures include not only the completion of questionnaires, psychological testing, and other less technical approaches, but also blood tests, nightly sleep electroencephalograms, continuous 24-hour monitoring of motor activity, and the use of double-blind drug studies. The majority of the patients admitted to the unit have major affective or schizophrenic disorders.

Sleep, motor activity, certain blood measurements, and clinical characteristics are investigated during the natural or baseline state of the illness, i.e., before the initiation of drug treatment, and during psychopharmacologic intervention. On occasion, this mandates withdrawing patients from medication and maintaining them drug free for a minimum of two weeks. The effect of psychotropic medication on these biological measurements is then studied through double-blind techniques.

Complementing the therapeutic milieu, all patients receive individual psychotherapy, group therapy, and family therapy. There are approximately 30 full-time staff members, including 2 staff psychiatrists and 3 psychiatric residents.

RATIONALE FOR THE THERAPEUTIC MILIEU

The therapeutic community has occasionally been presumed to be a beneficial treatment setting for a clinical research ward because it provides a model in which the patient is likely to behave as a collaborative ally and to participate actively in the collection of data (1, 2). With the research ward structured as a milieu setting, it was anticipated that the investigative efforts would lose much of their dehumanizing qualities and that a syntonic balance between research and treatment could be established.

We also expected that the well-structured milieu environment could significantly assist in delaying the administration of active medication in the control of psychotic patients and that the milieu might enhance any placebo effect. Furthermore, although no real data exist to support this idea, we believe that the incidence of spontaneous remissions may be higher in an active milieu program than in a locked, regressive ward setting. Biological data collected during spontaneous remission are considered to be extremely important, especially in investigations of the switch processes in psychiatric illnesses.

But perhaps the more compelling motivation behind our choice of a therapeutic community was the prevailing

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The opinions expressed here are those of the authors and do not necessarily reflect the views of the Department of the Air Force.

social climate in psychiatry. Complete with open door, team approach, and patient government, the therapeutic community projects an image of enlightenment—offering freedom, dignity, and responsibility to the psychiatric patient (4, 6). In fact, as Maxmen and Tucker (7) pointed out, milieu treatment has become so popular that "no self-respecting hospital psychiatrist could ever confess to *not* running a therapeutic community."

While the milieu approach may well be overused, it is specifically indicated in the evaluation and correction of disturbances in psychosocial functioning. With its emphasis on group and family interaction, the milieu setting can effectively rehabilitate the patient with interpersonal difficulties by teaching him basic psychosocial skills (7–10).

CONFLICTS

While some authors (1–3, 5) have enumerated a variety of basic issues that place clinical treatment aims in conflict with research objectives, no one has specifically discussed the applicability of milieu therapy to a biologically oriented research ward, even though this treatment modality has been in popular use on research wards. In fact, we are of the opinion that a number of factors inherent in milieu treatment make it inimical to pursuing the study of biological measurements in disorders of cognition and affect. The therapeutic community and the research ward may be considered antithetical concepts, not only in their goals but also in their approach to patients, staff decision making, and treatment of certain disease entities. The rapid relief of suffering may preclude the accurate collection of baseline data, and vice versa.

Fundamental to the therapeutic community is the establishment of an atmosphere that encourages patients to take active responsibility for themselves and others. Instead of being passive recipients of the staff's therapeutic efforts, the patients are expected to participate actively and become agents of change themselves (8).

The research patient, on the other hand, is required by the very nature of his admission contract to be a more passive figure and to comply with the mandate of the staff. He "cannot" refuse research procedures (2). In return for agreeing to participate in research, the patient may receive free clinical care. While the patient may be a collaborative ally theoretically, he is actually a passive consenter. Collaboration appears in such minor areas as collecting urine specimens, filling out self-rating questionnaires, or recording time spent off the ward. Major decisions, such as use of medication or passes out of the hospital, are decided by the ward chief, who expects the patient's passive compliance and even relies on it. Indeed, since research decisions are nonnegotiable, it is only through the patient's ready acquiescence that the protocol can be conducted smoothly and efficiently.

In milieu treatment, community considerations predominate over individual ones, while the opposite holds true for the biological research ward. It is this emphasis on the community and community goals which makes this modality useful in inculcating appropriate psychosocial skills (7, 9). Disorganized or aberrant thinking, deviancy, dependency, or other pathological behavior may be quashed and considered impermissible in the milieu, as it would be in society at large.

The research ward, however, either openly tolerates or passively encourages pathologic behavior in the attempt to collect baseline data on untreated natural disease states. Whereas in the milieu setting a patient with an escalating psychosis might be chemically or physically restrained for the comfort of the community as well as to demonstrate the unacceptability of such behavior, on the research ward this behavior is endured, recorded, and valued as an example of psychosis in the pure state.

Milieu therapy readily and expediently imposes controls on symptomatic or pathologic behavior (9) in an effort to impart and teach psychosocial skills. On the other hand, the research clinician may fail to employ the milieu to enforce proper therapeutic limits and may neglect to effectively confront the acting-out research patient. The therapeutic community ultimately relies on the active use of medication to control pathologic behavior and to rehabilitate the psychotic patient rapidly to a level of functioning at which he can assume responsibility for himself and, eventually, for others (11, 12). In order to secure optimal research data, however, pathology must not be altered by symptom removal. Consequently, the research patient remains untreated and is kept in the psychotic phase for an extended period of time.

Even after treatment has been instituted a placebo may be substituted and a relapse may be induced because of the double-blind nature of the research setting (2). Such an event is, of course, demoralizing to the individual patient, the staff, and the entire community in the milieu because they are conditioned to espouse the credo, "Have faith in the ward and trust in the effectiveness of the milieu, staff, and patients." The staff feel frustrated and ineffective and may lose confidence in the treatment setting when the patient on placebo fails to improve or relapses (2, 13). This response may be due to the large number of staff in the milieu setting.

At worst, the guilt induced in the staff by the use of placebo in acutely ill patients may be reflected in acting-out behavior by the staff, which not infrequently takes the form of medication mix-ups—an active medication may inadvertently be given instead of the placebo (14).

The therapeutic community, with its air of democracy and alleged narrowing of the staff hierarchy, traditionally employs the team model; all staff have input to the formulation of a treatment plan. When attempted on a research ward, this approach is weakened and made ineffective because medication decisions are actually formulated and transmitted by the clinical chief, who assesses which drug suits current research needs. The same holds true for decisions on hospital passes and any other decisions that affect active protocol patients.

Another universal feature of the therapeutic community is the open door, perhaps the sine qua non of enlightened hospital care (4). This invariable component also interferes with the smooth operation of the biologically

oriented research ward. The open door is nevertheless essential for the milieu's task of intensive resocialization, which includes the goal of letting patients leave the floor on pass, take walks, and slowly acclimate themselves to the outside environment. For example, the continuous 24-hour collection of data on motor activity (which can be telemetrically monitored only when the patient is on the ward) is interrupted and is therefore inaccurate when the patients are traveling on and off the floor. In addition, according to the milieu's emphasis on the patient's resocialization, taking initiative, and assuming responsibility, a rapidly cycling hypomanic patient would be able to leave the ward on extended passes before active medication was initiated. This would result in the loss of much baseline data. Another research disadvantage of the open door policy is the obstacle it presents to keeping illicit drugs off the floor and away from adolescent borderline and schizophrenic patients.

Another concept held in contradiction by the research and the milieu schools is the role of stress. In the milieu setting, stress is considered an integral part of living with which the patient must learn to contend. It is therefore only minimally reduced and usually not eliminated. The numerous groups, family meetings, and patient-staff meetings ensure frequent stressful situations (8, 10, 15), which may produce factitious findings in the monitoring of a number of biological measurements such as observations of motor activity or levels of corticosteroids or catecholamines. A research ward that emphasizes supportive approaches and avoids stress-inducing situations may be more efficient in studying psychosis and the effect of medication on a variety of biological measurements. The combination of an open door, with patients on and off the ward, and frequent stressful groups may have resulted in our finding (16, 17) that monitoring motor activity or steroid or catecholamine levels was more fruitful in the evening hours, when the patient was free from external pressures or ward activities.

MILIEU TREATMENT AND SPECIFIC DIAGNOSES

We have attempted to demonstrate how certain principles basic to milieu treatment are, in fact, counterproductive to the functioning of a research ward studying biological phenomena in psychiatric disorders. Not only do certain aspects of milieu treatment interfere with the orderly collection of research data, but the specific disease entities under investigation, such as schizophrenia and the affective disorders, are often ill served by an active milieu setting.

As described, the milieu setting, with its emphasis on forced social interaction and participation in various group meetings, provides complex and intense stimulus input for the disorganized schizophrenic patient. The seclusiveness and isolation of the schizophrenic patient represent not merely pathology but also a defense that should be respected until the patient can contend with increased stimulation (18, 19). The environment for schizophrenic patients should be simplified and unambiguous; patients should receive cues in clear, concrete language (12, 20, 21). That archetypal milieu phrase "talk about it" serves no such function for the disorganized schizophrenic patient. It is for these reasons that others have warned of the deleterious effect of an intense milieu on schizophrenic patients (11, 12, 18, 22) and have recommended reduction of arousal and removal of stress (16, 18).

Case Reports

Case 1. A 26-year-old single man who had been diagnosed during his only previous psychiatric hospitalization as an acute schizophrenic was admitted to the research unit because he was complaining of suicidal ideation and because the admitting physician noticed some delusional ideas about food. On admission, the admitting resident described the patient as a "distant, depressed white male with flat affect, speaking somewhat tangentially. Completely oriented, intellect and memory good."

The patient had not been taking any medication before admission and he was kept drug free on the ward. Although he was noted to be "preoccupied with transcendental meditation," both nursing notes and physician's progress notes over the next several days documented his cooperative attitude, his willing participation at meetings, and his help with the other patients.

However, by the fifth day of hospitalization, he was noted to be increasingly anxious and more isolated. His depression seemed more severe, he was no longer able to sit through community meetings, and his behavior became intermittently inappropriate. He began refusing to eat and he "attempted to elope from the unit, saying he needs to get out to get his thoughts together. ... [He is] afraid of contaminating other patients with his evil" (nursing notes).

By the sixth day of hospitalization, he was requesting medication. His sleep was becoming increasingly disrupted, he made a suicidal gesture, and he was placed in a cold wet-pack upon request. "He felt he was losing control. He had to be medicated" (nursing notes). This occurred at 1:00 a.m. on the seventh day of hospitalization, by which time he was actively psychotic. Phenothiazines were administered at this time, and he quickly responded favorably.

With the benefits of the therapeutic community accruing in the area of psychosocial rehabilitation, those patients with difficulties in this area would most benefit from a milieu setting. The elderly depressive patient with no previous psychiatric hospitalization and with a satisfactory marriage, work history, and social history would probably do better elsewhere. Such a patient might find a therapeutic community a meaningless experience at best; at worst he might become disorganized by the complexities of a milieu treatment.

Case 2. This 59-year-old man had no previous psychiatric history. He owned a bar, had been married for 35 years, and had three grown children. Three months before admission he began experiencing apprehension concerning the impending sale of his bar and began ruminating about whether he could fulfill his financial obligations. Over this period he became increasingly anxious, agitated, and irritable. He experienced interrupted sleep, diminished appetite, a 10-pound weight loss, constipation, anergia, and social withdrawal.

On admission, he appeared neat and cooperative, but guarded. He frequently wrung his hands, showed a worried ex-

pression, and had a depressed affect. He blamed himself for stealing from a business partner. There was no evidence of psychosis and he had been drug free. He received no medication at this time on the unit.

The second evening after admission he expressed fear that he or his family might be harmed in the hospital; the following day he believed his food to be poisoned. He feared transfer to a jail for having cheated his partner. Nevertheless, during the first four days of hospitalization he responded well to staff reassurance and was able to sit through meetings and even to make appropriate, although infrequent, comments. On the sixth day of hospitalization his controls became tenuous. He made innumerable phone calls home to convince himself that his family was there and tore his clothes in anguish. Yet when his family visited that day he regained control. The next day his agitation and delusions persisted and he openly expressed concern and worry over all the unit activities.

On the eighth day of hospitalization he lost control. Fearing harm from the staff, he barricaded himself in a room armed with a lamp and started striking out. At this point the research protocol was abandoned and medication was started. He responded well to the medication and was discharged to his home. Neurological investigation during his hospital stay had been entirely normal.

Certain patients with character or so-called borderline disturbances regress markedly in the democratic, nonauthoritarian environment of the milieu (23–25). Since these patients invariably display better controls than do overtly psychotic patients on admission, the staff assumes they can function reasonably well and will work readily toward the community's goals. However, this type of patient quickly discerns and discards this expectation as he observes the more disorganized patients receiving intensive staff care. He may then reject taking responsibility for himself or others. Longingly noticing other patients who receive continuous staff attention, yet with his own insatiable need for gratification remaining unmet, the patient may yield to regressive temptations. Ultimately, in the hope that self-injury will gratify his dependency needs by evoking care and attention from the staff, the patient may resort to self-mutilative or suicidal gestures or begin to use illicit drugs on the ward (25, 26).

Unfortunately, the remedy for countering such regressive dependent behavior, i.e., cohesive and united staff attitude, is actually a difficult and unlikely accomplishment in a heavily staffed, team-oriented, nonauthoritarian milieu. It is of interest that these patients can quickly reverse their regressive behavior in a custodial, authoritarian, unpleasant environment (1, 4).

In addition to the numerous other incompatibilities between the clinical research ward and the therapeutic milieu described in this paper, we also point out that the extra cost of the milieu setting, in terms of the necessity for increased staffing and the apparently accelerated loss of research patients during the protocol period, must be carefully considered.

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Limitations and Values of Evaluation Techniques in Psychiatric Education

BY S. MOUCHLY SMALL, M.D.

The author presents a summary of the major evaluation techniques now available and discusses the values and limitations of each. He concludes that only by the use of many evaluation instruments during the resident's period of training can some estimate of clinical competence be approached. Even with this multiplicity of testing instruments, the validity of predictions of a psychiatrist's performance can be determined only in terms of probabilities.

THE GOAL OF MEDICAL EDUCATION is to produce a physician with the knowledge, skills, attitudes, and judgment that he will use to provide professional services of high quality. Having stated the goal, it is then necessary to describe the factors involved in achieving it in more specific operational terms for the construction of curriculum and, ultimately, for the evaluation of both the program and its graduates.

Knowledge can be stated in a fairly precise fashion, although the expansion and diversification of curricula reflect its complexity. Skills can also be defined, but they are less subject to quantification than are understanding and factual knowledge. Attitudes and judgment are much more difficult to outline or measure and are usually expressed in a more qualitative fashion than other measurements (1).

Under the present system, responsibility for undergraduate and graduate education is divided between medical schools and hospitals. There is a lack of coordination between these responsible institutions except in instances where faculty and staff overlap. Examinations in medical colleges have traditionally covered the basic sciences and clinical subjects separately. Their application (subsumed under the general term "clinical competence") is minimally tested in the schools but has been emphasized during the internship and, more particularly, during specialty training. The evaluation of clinical skills stresses diagnosis, management, technical skills, and patient-physician relationships rather than theoretical knowledge. Recently, increasing consumer demands for professional accountability have led to an even greater emphasis on aspects of competence that are clinically relevant and significant.

Evaluation techniques for psychiatric residents must change as the educational and scientific bases of medicine and psychiatry progress and as changing patterns in the health care system evolve. Furthermore, the all-embracing nature of modern psychiatry, including the contributions made by disciplines ranging from biophysics to ethology, involve psychiatric subspecializations of all sorts—child psychiatry, community psychiatry, forensic psychiatry, administrative psychiatry, and the various therapeutic modalities such as psychoanalysis, dynamically oriented psychotherapies, family therapy, and behavior therapy. Such diversity makes it impossible to incorporate the teaching of psychiatry into a single educational sequence or testing program (2) and requires an appraisal of what is considered essential as differentiated from elective.

Holland and Stoller (3) formulated the core characteristics of a psychiatrist, i.e., the psychiatrist has comprehensive knowledge and understanding of the physical and behavioral dynamics of the human being, possesses diagnostic skill and therapeutic judgment, operates within the professional code of medical ethics, and has a deep sense of responsibility. With these characteristics as an orientation, we must come to some agreement about the level of knowledge and skill the psychiatrist must possess and then design and use a great many evaluation instruments to determine whether the resident has reached the required levels. It would also be desirable to determine if the psychiatrist in practice continues to update his cognitive and technical skills and maintain a level of performance comparable to his performance at the time of examination as a resident.

Effective methods for evaluating the psychiatric resident's general knowledge and clinical competence are required to ensure that he has mastered the fundamentals of psychiatry. What these essentials or goals of the residency should be often reflect the self-image held by the group of successful specialists who participate in constructing the curriculum and developing professional criteria to achieve these objectives. Even when the goals are not very specifically elucidated, most training programs agree on the time frame (usually three years for psychiatry) and the means by which they are to be achieved.

Testing may be used in a number of ways, including the following: 1) to protect the public by ensuring a certain minimum of professional competence and safety, 2) to provide data for programmatic decisions about the teaching-learning program and the abilities of the instructors and supervisors, and 3) to define areas of strengths and weaknesses for the individual resident; he can use these in a constructive fashion to improve himself.

The basic limitation of any examination tool for clinical competence is that it presumes to be predictive in na-

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ture; it supposedly predicts whether or not a given candidate is likely to be competent in his future clinical dealings. An examination cannot pretend to be infallible because it cannot encompass future conditions or the future development of the examinee. It should be obvious that the predictive validity of any examination can be seen only in terms of probabilities, not in terms of certainties (4).

There is probably no technique, including peer review and direct observation of clinical performance, that really helps us to predict with a high degree of reliability at any given moment in time how a physician will perform in the future in a private, unobserved clinical situation. Most of us can probably attest to the fact that we show changes in attitude, approach, clinical technique, and formulations that are consciously and unconsciously modified by the presence of an observer or by the recording of the patient-doctor interaction (5).

Thus the most serious universal limitation of all individual and group testing is probably the lack of certainty that the abilities demonstrated on the examinations can and will be used in providing medical services and that an acceptable standard of medical care will be ensured.

Although our evaluative techniques are imperfect, we cannot delay until the mechanisms for testing are ideal. We need to participate in a continuing analysis of the changes in goals and objectives and to reflect them in our evaluation methodologies. Testing may be adequate for certain aspects of residency training; in other areas we may have to settle for an analysis of effort. For example, it might be of value to know how much a resident reads, how many hours he uses for study in the specialty, his regularity in attending rounds, conferences, and seminars, whether he maintains good medical records, the concern he shows for patients, and other aspects of his day-to-day clinical work. Again, there is no evidence that these activities have a high degree of correlation with clinical effectiveness. Nevertheless, their "face validity" is compelling.

EVALUATION PROCESSES

At varying points in the resident's educational program and development, it is beneficial to evaluate knowledge and cognitive understanding in a longitudinal fashion. This allows the resident to compare himself within the program's time frame as well as with his peers. Although it is an unproven assumption that these measures relate to clinical competence and skill, it seems clear that clinical effectiveness and high quality performance are patently impossible without a cognitive base.

Oral Examinations

Oral examinations are notoriously low in reliability; they become less effective, more expensive, and more time consuming as the number of examinees increases. At present they are used primarily in psychiatric board certification examinations to evaluate interviewing skills, attitudes, capacity for empathy, judgment, and the clinical application of knowledge and understanding. For example, an insensitive candidate who is a poor observer, who treats the patient brusquely, who uses inappropriate language, who doesn't follow up cues given by the patient, who does not make effective contact because he is too busy taking notes, and who omits obvious possibilities in discussing differential diagnosis, therapeutic options, and psychosocial factors would be considered inadequate or unsafe for that particular clinical situation.

Improvement in scoring and reliability is usually achieved if a checklist of items to evaluate the candidate is used. Ideally, the only variable should be the examinee's clinical competence, but this is not the case because different patients as well as different examiners are involved. Some of the variables may be minimized by using simulation techniques with professional actors trained to portray certain patient attitudes, feelings, and thoughts. Some improvement in reliability has been shown when videotapes of interviews have been used.

Essay Examinations

Essay questions are easy to compose and give the resident an opportunity to show how well he can organize and express his thoughts concerning the most complex types of clinical situations in an orderly, logical, and lucid manner. However, essay questions have many drawbacks and limitations. Proper sampling of such an extensive field as psychiatry within reasonable time limits is impossible. Increasing the number of questions, shortening the time allowed for responses, and allowing the examinee some choice of questions decrease the sampling error but do not overcome the halo effect of grammar, spelling, and legibility of handwriting or the effect of repeatedly demonstrated lack of test reliability shown by comparing scores of two or more examiners. Reliability is poor even when the same individual scores the same group of responses after a time interval (6).

Multiple-Choice Tests

The technique of multiple-choice tests was applied to medical examinations about 1951. As a result of extensive experience, the variety of multiple-choice questions has been cut back to three basic types.

1. One-best-response type (type A). This is the type most commonly used. Each item (question) consists of a stem that is a statement, case history, chart, graph, or picture followed by four or five suggested answers. Only one of the answers is correct; the others are called distracters. The best or most appropriate response must be selected. Some of the distracters may be partially true. With a five-choice item, there is a 20 percent chance of guessing correctly.

2. Matching types (type B). A list of lettered headings (usually five) is followed by a list of words or phrases. The examinee selects the heading most closely related to the words or phrases. By inserting "none of the above" as an entry in the lettered heading, the item is made much more difficult because the examinee must think of possible associations other than those stated.

Another form of matching item (type C) offers four possible answers. The candidate is directed to select response A if the word or phrase is associated with A only, select B if the word or phrase is associated with B only, C if associated with both A and B, and D if associated with neither A nor B.

3. Multiple true-false types. In type K of this group, the stem may be in the form of a statement, question, case history, clinical data, or pictorial material. This is usually followed by four unequivocally true or false statements. Five combinations of responses are usually offered. These are not mutually exclusive but one combination must be selected. This type of item tests the depth of the examinee's knowledge and understanding of several aspects of a disease, process, or procedure.

With type-X multiple true-false items, the candidate scores any combination of rights and wrongs. The directions for this type of question are less complex and the examinee gets some credit for partial knowledge. However, it has the disadvantage of weighting a particular item too heavily. Furthermore, a comparative study of multiple true-false items using types K and X does not show significant differences in the rank order of the candidates for reliability and effectiveness (7, pp. 20–31).

The use of multiple-choice tests in medical examinations provides a vastly improved sampling, a high degree of reliability, objective machine scoring, and valuable information about areas of strength, weakness, and misconception. Computer printouts give P values (the percentage of examinees who answer each item correctly) and biserial correlation coefficient values (r). These show how well each question discriminates between well-qualified and weak examinees and allow for constant improvement of the item by eliminating distracters that are not performing well.

The criticism that most written examinations test only memory (8) confuses the issue by equating cognitive understanding and knowledge with straight recall. Knowledge consists of such things as facts, ideas, explanations, meanings, processes, procedures, relations, and consequences (9). The examinee must think and conceptualize as well as remember. Well-written test items require the candidate to retrieve, select, organize, and apply his knowledge. Too often the fault is not with the form of the item itself but with the writer. We need to develop and train more competent and highly qualified psychiatrists who are willing to devote enough time to write meaningful, significant, relevant, and effectively discriminatory items of moderate difficulty. Only then will we have explored the full potential of this type of technique for psychiatry.

Patient-Management Problem Tests

Tests involving patient-management problems typically begin with the presentation of a brief clinical history, physical examination, and routine laboratory tests that are representative of diagnostic and management problems thought to be important or signal in nature. The examinee is required to select the most appropriate courses of action out of a given number. In selecting an answer, he erases a portion of a plastic overlay, revealing information underneath. The information revealed may be useful or may merely disclose that his selection is noted. Armed with this new information, the examinee proceeds to more detailed clinical problems about the same patient (10).

The content of such tests is obtained by use of the critical incident technique. Physicians with acknowledged expertise are asked to report examples of conspicuously good or poor (inappropriate) clinical practice. From thousands of such incidents, major areas of clinical performance are defined, i.e., history taking, physical examination, use of tests and procedures, diagnostic acumen, treatment, judgment, skill in implementing care, physician-patient relationship, continuing care, and responsibility as a physician. These definitions provide test makers with ideas of what is to be tested (5).

This type of testing obviously differs from real clinical situations in which the examinee has to originate alternatives rather than select from multiple choices. The scoring gives credit for correct decisions and penalizes the candidate for omitting important procedures or choosing those which are harmful to the patient. Correct selections made from a relatively large number of alternatives give the examinee additional information that will often help him with the next problem concerning the same patient.

According to Hubbard (7) the reliability of this type of testing is generally at the level of .80 to .85 (7, pp. 40–50). Unfortunately, the interdependency of related responses has the effect of decreasing the reliability of the test. Schumacher (11) questioned the value of this format on the basis that a specialty examination in internal medicine showed no significant performance increment after two years of residency training in that specialty. Similar findings have been reported for residents in orthopedic surgery (12).

Despite these adverse reports, this type of examination appears to have validity and has considerable appeal to the examinees. According to my personal experience, which has been corroborated by others who have constructed many such items, special expertise is required to construct such problems without giving away information that enables the examinee to backtrack to previous questions about the same patient and correct his errors. This can be avoided with a computerized test or with special techniques yet to be evolved. Furthermore, there is a wide range in discriminatory power between various problems of this type.

We have yet to learn how to refine this particular technique so that it may show a significant difference between well-trained physicians and those who are less clinically competent. However, it seems that this format, coupled with other types of tests, may have the potential for achieving a significant advance toward the goal of developing standardized, reliable, and valid instruments for evaluating some aspects of clinical competence.

Peer Review

The approach of peer review has value because it measures actual clinical effectiveness as it is evaluated by cli-

nicians. This technique suffers from practical uncertainties such as variation in definition of levels of competence, inadequate sampling, logistic difficulties when it involves large numbers of professionals, and great difficulty in proving reliability and validity. It is, however, unambiguously focused on the presumed concern of all tests in medicine, namely, the quality of care actually provided for real patients.

Simulation Techniques

There is a large number of simulated clinical situation techniques, including the computerization of methodology for patient-management problems. These vary in their approximation to real-life situations. Testing with films or film clips is expensive, especially if color film is used. Many of the test items in specific simulation tests have been either too easy or too difficult and have failed to discriminate between a more able and a less able group. The use of filmed material has been abandoned by the National Board of Medical Examiners on part III of its test (13).

There are many types of audiovisual presentations. One of these involves the examinee's asking and answering clinical questions regarding a patient whose complaints and history have been presented by a computer. The computer answers the examinee's questions about the clinical situation and records the examinee's working diagnosis and plan for management and treatment. Such techniques are hampered by large development costs and the complexity of the analytic work necessary to provide widely applicable results.

CONCLUSIONS

Of necessity, this short paper can provide only a summary of the major evaluation techniques now available. The discussion of their values and limitations is similarly scanty. What is clear is that only by using many evaluation instruments during the resident's period of training can one approach some estimate of the elusive goal of clinical competence. Even with these instruments, it is apparent that predictive validity for a psychiatrist's performance in the future can be determined only in terms of probabilities. The complexity of the newer techniques strongly suggests that evaluation research and teaching seminars for question writers have now become imperative if we are to improve our testing methodologies.

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Psychoemotional Aspects of Mastectomy: A Review of Recent Literature

BY MICHAEL J. ASKEN, M.A.

The author reviews the recent literature on the psychological aspects of mastectomy, including psychological reactions to the procedure and appropriate intervention strategies. He discusses individual and familial fears and concerns related to mastectomy and emphasizes the importance of preoperative counseling and postoperative rehabilitation.

THE IMPORTANCE OF psychological factors in physical medicine has long been recognized by medical practitioners. Jaco (1), for example, stressed the importance of treating the entire patient rather than collected and selected parts. Certain medical procedures save lives but also result in some degree of functional loss or disfigurement for the patient. This paper will consider the psychological aspects of mastectomy, which is such a procedure. I will present a review of the literature dealing with both psychological reactions to the mastectomy experience and appropriate therapeutic interventions.

PSYCHOLOGICAL ASPECTS

While mastectomy performs a gratifying service by saving a woman's life, her appreciation is muted by the price she must pay for that service—the loss of a breast and permanent disfigurement. Within the value system of American society, that price is a considerable one. The following statement describes the thoughts and feelings of a mastectomy patient:

> The only data my brain registered were that breast cancer with metastases has a short-term survival rate and I was mutilated.
>
> From the moment my physician said that I had metastatic breast cancer until two years after my surgery, I was frozen with fear. The people who are supportive to me were so shaken by my unexpected reaction that they ceased to function for me. The threat of death hung over me day and night, but I believe that the mutilation was more traumatic. Living became so arduous I found myself preparing to die on all levels—I stopped buying clothes or refurnishing my home as needed; I arranged my work each day as though tomorrow were not coming; and, finally, I developed a speech pattern which became death oriented. (2, pp. 676, 677)

These words were spoken by a practicing registered nurse, a professional who is medically sophisticated and actively involved with helping others to accept their misfortunes. The impact of the mastectomy experience must, therefore, be exponentially increased for those leading more sheltered lives. Indeed, Roberts and associates (3) reported that 51 percent of their sample of mastectomized women admitted anxiety or depression; the authors concluded that there is an important psychological morbidity associated with all operations for primary breast cancer. Ervin (4) expressed the belief that emotional suffering outweighs physical pain in mastectomy cases.

Generally, the predominant psychological reactions to mastectomy are a sense of mutilation and a loss of feelings of femininity (4–8). Goldsmith and Alday (9) reported that mastectomy raises several fears in women. First, there is the anxiety associated with any major surgical operation. Perhaps more important than this, however, are the fears associated with breast loss: concern over sexual desirability, interpersonal and sexual relations, and, if the woman is married, dangers to her marriage. Third, there is the fear of death, an omnipresent consideration for all mastectomy patients. This fear is not always expressed overtly; it may sometimes undergo unconscious transformation and be expressed as fear of breast loss (although there is probably little reason to doubt the veracity of the latter concern). Mastectomy may assume a symbolic quality in other ways (10). The young patient may have a strong reaction to mastectomy as the operation suddenly forces her to confront her own mortality. In the older patient, mastectomy may confirm the debilitating effects of old age.

Lymphedema is another area of concern to women who undergo mastectomy (5). Healey (5) reported that the psychological fears about lymphedema include: 1) self-consciousness of the enlarged arm in the presence of others, 2) difficulty in fitting clothes, and 3) changes in lifestyle affecting social behavior.

Some women harbor myths and unanswered questions about the operation and its results. Klein (10) reported several misconceptions commonly held by the patient, including the belief that cancer always recurs or kills, that she will be perceived by others as untouchable, and that she is in some way responsible for her cancer. The patient may have many questions that she considers in-

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appropriate at the time of surgery; consequently, they may never be asked or answered. This lack of knowledge may cause considerable anxiety. The patient may wonder how she can keep her bra from riding up on the operated side and what sorts of special bathing suits are available to her (11).

The loss of a breast leaves the woman in the unusual situation of having only one breast, a condition that is apparently fraught with ambivalence. Leis (12) reported that much is made of the psychological importance of the remaining breast, which may be cherished as a badge of motherhood, a sign of femininity, and an important psychosexual symbol. Leis also noted, however, that the second breast remains as a nonfunctioning organ: few women display it as a "questionable" sexual stimulus next to a mastectomy scar, and few allow it to be used during the sexual act. Some doctors will not permit the remaining breast to be used in breast feeding. There is also the problem of disrupted body symmetry. Finally, patients may live with the fear of recurrent cancer in the remaining breast. Thus, this breast has both a positive and negative value to the patient, resulting in vacillating ambivalence.

Klein (10) observed that the adverse psychological effects from mastectomy may also affect the patient's family. The malaise may be transmitted by the patient herself through her own distorted self-view as a person unworthy and unable to readapt to her normal role. A husband's perceived inability to help his wife may cause guilty resignation to a vitiated and destructive marriage. Children may develop school problems as a response to their mother's inexplicable depression. Quite apart from the effects that a patient's altered mood may have on the family, the husband in particular may have some very real mastectomy-related concerns (10). Foremost is the question of his wife's survival. He may also be unsure how to respond to his wife after her operation and unsure of what new needs she will have for him to fulfill. Many husbands who are full of uncertainty and conflicting emotions may express their concerns by withdrawing and retreating from the situation; the wife may interpret this behavior as rejection, an especially psychologically detrimental misperception on her part.

INTERVENTION

Given the overall trauma of mastectomy, intervention with the breast cancer patient must involve both physical and psychological considerations. It has been suggested (13) that rehabilitation after mastectomy must be approached on three planes to cover both aspects successfully: physical, cosmetic, and emotional. Similarly, Dietz (14) proposed that the goals of mastectomy rehabilitation are the maintenance of the range and function of the arm and shoulder, the restoration of external appearance, and psychological adjustment (i.e., acceptance of breast loss, reintegration of the self-image as being worthy of love and the rewards of life, and adjustment to the possibility of cancer recurrence in the following years [10]). Also, the goal of intervention for the patient beyond help is to provide comfort in the terminal stage (15).

Physical Rehabilitation

Rehabilitative measures for mastectomy patients generally fall under the rubric of primary prevention, i.e., the prevention of adverse psychological reactions to the procedure. The preventive steps are instituted either pre- or postoperatively. In many cases the procedures and their timing are interchangeable or repeatable. The implementation schedule will most probably be dictated by the schedule of medical procedures, since the diagnosis and treatment of breast carcinoma are often almost concurrent (7).

The prevention of iatrogenic physical degeneration is accomplished through the use of both pre- and postoperative physical therapy. The use of physical therapy has been described by Beeby and Broeg (13), who outlined three objectives for the procedures: 1) to obtain and maintain complete ranges of ipsilateral and shoulder motion, 2) to prevent postural deformities such as protracted scapulae and kyphosis of the vertebral column, and 3) to counter all possible ill effects of lymphedema. Preoperative physical therapy is designed to prevent postoperative pneumonia, muscle degeneration, pooling of lymph fluids in the extremities, and postural deformities. Postoperative physical therapy includes introduction and explanation of procedures, evaluation of abilities, appropriate exercises, and discharge evaluation with instructions for home exercises.

Cosmetic Reconstruction

Emphasis on the cosmetic plane is, of course, one of the central issues involved in the controversy over the extent of surgical procedures required to adequately treat breast cancer. Beyond this problem, however, breast reconstruction is the only solution to the problem of disfigurement. Millard and associates (6) and Freeman (16) suggested that offering the chance for breast reconstruction even before the breast is removed can be of great comfort to the patient. Of course, any safe procedures that limit the destruction of the breast are desirable; to accomplish this, Millard and associates (6) offered a procedure for saving the uninvolved nipple. The nipple-banking procedure consists of temporary grafting of the nipple until it can be replaced onto the reconstructed breast. The authors found this procedure to be a great morale booster, giving the woman something to look forward to and serving as a token of the doctor's faith in her recovery. It has been suggested that women should be allowed to have simple breast reconstruction postoperatively (8). The use of silicone implants has been cited as a quick method that produces "no cosmetic triumphs" but often obtains "astounding" psychological improvement (7).

Counseling

The obvious purpose of cosmetic reconstruction is to ease psychological adaptation, but preoperative and postoperative counseling (preferably both) are also manda-

tory. Dietz (14) suggested that the use of counseling is dependent on the needs of the patient but that its goal should be to prescribe an individually suitable rehabilitation program. The following counseling procedures are arbitrarily designated as either pre- or postoperative measures, depending on their classification in the literature; however, their administration is flexible.

Klein (10) presented examples of content to be covered in preoperative counseling with the mastectomy patient. He suggested that the patient should be helped to consider what to tell the significant people in her life about her situation. Children will inevitably become aware of the change in familial routine. Younger children may feel deserted by a hospitalized mother, and older children may put together their own ideas about the surgery from bits of conversation; special consideration should be directed to the teenage girl, who may be wondering if she will suffer the same tragedy. Frankness is advocated as the best means of combating emergent fantasies. Adult discussion also provides a good model of healthy coping patterns.

Counseling also attempts to help the patient to anticipate the future. The length of rehabilitation and the role the patient must play in it are important areas for discussion. Harrell (2) reported that the function of the counseling interview is to provide information to the patient. She suggested that the patient be assured that crying spells are normal and to be expected, that sleeplessness or nightmares may occur, that some numbness in the arm is natural and no cause for alarm, and that breast forms are available and should provide confidence and comfort. Markel (11) reported that during the preoperative interview patients should be encouraged to express questions of importance to them, and Klein (10) suggested that misconceptions that are held about the procedure and its implications must be dispelled. Klein (10) also cautioned, however, that false assurances must never be given because the future in any respect can not be guaranteed.

In regard to postoperative counseling, Harrell (2) stressed the appropriateness of the postsurgical hospitalization period for primary prevention and secondary intervention. This period provides for continuity of care and also presents a situation in which the patient and family are together so that common problems, questions, and misbeliefs can be attended to. In short, the hospitalization period provides an excellent opportunity for reaching the patient and her family.

Another facet of postoperative intervention reputed to be of value is a mechanism to allow patients to express either residual or newly emerging feelings of concern (10). This goal can be achieved through group therapy, although in all cases individual consideration should be paramount (5, 14). A program that uses a team approach to incorporate many of the points suggested is reported in the literature (17). The team is comprised of the patient, nurse, physical therapist, and recovery worker, who meet daily in a class-type atmosphere. The purposes of the meeting include instruction in beneficial exercises, communication of information about prosthetic devices, and provision of a forum for the discussion of questions and feelings. The strongest factor in this approach is the group itself, in which patients help each other.

The usefulness of prosthetics clinics has been reported by Akehurst (8). The clinic described is held concurrently with joint breast and radiotherapy clinics. It is staffed by a woman fitter and a lay worker who is a former mastectomy patient. Visits by a former mastectomy patient who is currently looking and functioning well is a technique that has great psychological benefits and receives almost universal support (3, 5, 8, 11, 17). Akehurst (8) reported that the use of the former mastectomy patient is vital to rehabilitation, because having suffered the physical and mental effects of the operation, she is the only person who can talk to the patient with real understanding. The lay worker is often part of the Reach to Recovery program endorsed by the American Cancer Society (11) and by medical professionals (4, 18). In addition to workers who are part of this mastectomy rehabilitation program, the society distributes a film entitled "Recovery After Mastectomy," which may be used in place of or as a supplement to the recovery worker (11). A manual on mastectomy written for the patient by Lasser (19) and an article by Aves (20) describing swimwear for the mastectomy patient would also be useful in the treatment of mastectomy patients.

There are two other aspects of postoperative programs that are essential to rehabilitation. The first is the requirement of counseling for the family of the mastectomy patient (10, 21). The second is proper discharge planning to ease readjustment into normal life (5).

The Surgeon's Role

The surgeon or gynecologist transverses the entire experience of mastectomy. In the psychological sphere, his role has too often been avoided or left unfilled (7, 22). Klein (10) reported that the surgeon is central to helping a woman accept the mastectomy. This is so not only because he has the greatest opportunity to help but also because he is perceived as knowledgeable, skilled, and godlike by both the patient and the family and because the patient is eager to believe in his power to cure both the body and the psyche.

Unfortunately, the surgical role presents practical problems that inhibit the surgeon's ability to respond as a palliative psychological agent. Heavy caseloads and the demands of surgery preclude the establishment of more than a fleeting relationship. Despite these inhibitions, however, the surgeon can engage in simple behaviors that will aid in postoperative adjustment. Psychological intervention can begin at the precise moment that the necessity for mastectomy is determined and may be effected by stressing any positive aspects of the situation (such as small tumor size or the short time interval between diagnosis and removal) and by being aware of female and familial concerns and fears. The surgeon may see to it that appropriate ameliorative measures are instituted or administered postoperatively (9). Ervin (4), a surgeon who has been impressed with the psychological morbidity of mastectomy, has outlined a counseling technique he

uses with mastectomy cases that centers on honesty, hope, and the involvement of the husband.

It is imperative to remember, as Markel (11) has pointed out, that in the patient with breast cancer, postoperative treatment and rehabilitation cannot be separated; if rehabilitation has not been accomplished, postoperative treatment is incomplete. To this must be added the necessity of preoperative preparation.

Finally, words written by Harrell (2) once again seem appropriate.

> To save a woman by surgical intervention and then deny her emotional support necessary to form a different lifestyle and accept an altered body image is a contradiction in terms. (p. 676)

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EDITORIAL

Greetings and Thanks

THE YEAR 1975 marks the 10th anniversary of the change of editorship of the journal of the American Psychiatric Association. The present editors assumed office with some trepidation. For 32 years the distinguished Clarence B. Farrar had edited the *Journal* almost single-handedly and following him would be no easy task. Fortunately, nearly everyone was kind and helpful and we have survived thus far—this despite the fact that we perforce must occasionally send authors' brainchildren back to them, and this does not make us generally beloved.

We are indeed grateful for the help we have received, and we note that fact in each January issue. We know, too, that when we appeal for help we are encroaching upon the time of busy colleagues, but we always hope that they realize that this is their journal and that their help and expertise help keep it at its present high level. We hasten to add, however, that final decisions must rest with the Editor, and whenever clinkers get into our publication, the responsibility is his alone.

Therefore the Editor, the Managing Editor, the Editorial Board, and the staff take this occasion to especially thank the colleagues listed below for their help from November 1, 1973, to November 1, 1974.

We are grateful to our book reviewers, also, but because they sign their reviews and the readership is thus familiar with their contributions, we have not listed them here.

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Unfortunately, in an operation of this size someone's name may be omitted, perhaps someone to whom we are especially indebted. We apologize in advance should this happen, and we would like to hear about our errors of omission and commission.

The editorial staff notes particularly its indebtedness to Dr. Walter Barton and wishes him well in his new venture. We look forward to working in pleasant symbiosis with our new Medical Director, the distinguished Dr. Melvin Sabshin. To Drs. Donald W. Hammersley and Henry H. Work, and to Mr. Robert L. Robinson, Mr. Raymond M. Glasscote, and Ms. Jean Jones—all of the APA staff—go our special thanks for their continued courteous assistance and cooperation.

Our greetings to all of our colleagues and readers and our hopes that their New Year will be the happiest ever.

F.J.B.

The Psychiatrist's Involvement with Aged Patients

BY FLOYD K. GARETZ, M.D.

The author studied via questionnaire psychiatrists' involvement with older patients in relation to their own ages and the nature of their practices. Older psychiatrists see a higher proportion of older patients, advocate more comprehensive treatment, and find older patients more interesting and gratifying. Psychiatrists in general psychiatry and those who have a primarily inpatient practice see the largest proportion of older patients.

LARGE NUMBERS of aged people in the United States experience mental and emotional disorders, yet the elderly appear to underutilize psychiatric services (1–3). Although several authors have investigated this phenomenon (4–6), many questions remain unanswered. The present research is based on a questionnaire study of psychiatrists regarding their involvement with older psychiatric patients.

METHOD

All members of the Minnesota Psychiatric Society who were available for sampling (N=202) were asked to complete a questionnaire that yielded data on their ages, professional interests, and types of practice. In addition, data were collected on their experiences with, perceptions of, and attitudes toward older patients (those over the age of 65). The data were in the form of either continuous variables (age of psychiatrist and percentage of older patients seen) or categorical variables (the remaining data). Correlation coefficients were used for comparison of continuous variables, and categorical variables were compared with each other by chi-square tests. Continuous variables were compared with categorical variables by analysis of variance and F and t tests.

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RESULTS

Ninety-one percent (N=184) of the psychiatrists polled responded. Their mean age was 45.7, with a range of 27–80 years. Nearly two-thirds of the respondents worked in the Twin City metropolitan area; the other third worked in smaller communities. Forty percent of the sample were working primarily in public settings, with the remainder in part- or full-time private practice. Less than 4 percent of the sample reported a special interest in geriatric psychiatry, and the proportion of older patients seen in the entire sample was 10.9 percent of the total case load. Table 1 presents these and other descriptive data related to preferred mode of treatment, area of interest, and type of practice.

Four specific constellations of variables were analyzed for significant relationships; the results of these analyses will be presented in the following sections.

There were several significant relationships involving psychiatrists' ages. The mean age of the 20 psychiatrists who more often made the diagnosis of anxiety in older patients (64.5 years) was higher than the mean age of the 77 psychiatrists who more often diagnosed organic brain syndrome (43.0 years) ($p < .001$, t test). Younger psychiatrists more often thought evaluation and somatic treatment were indicated in aged patients, whereas older psychiatrists more often advocated more comprehensive treatment, including psychotherapy ($p < .06$). Psychiatrists who found older patients more interesting (N=115) were significantly older on the average than those who found these patients less interesting (N=38) (means of 46.75 and 41.34 years, $p < .05$, t test). Also, the 121 psychiatrists who found older patients more gratifying were older than the 31 who found them less so (means of 47.21 and 36.61 years, $p < .001$, t test).

Area of Special Interest

The responses to this question were coded into the five categories listed in table 1, and the following relationships were found to be significant: 1) General psychia-

TABLE 1
Data on the Practices of Psychiatrists Surveyed (N = 184)

Item	Number	Percent
Area of interest		
General	123	66.84
Child-adolescent	18	9.78
Psychoanalytic	19	10.32
Geriatric	7	3.81
Social and community	11	5.98
Other	6	3.27
Type of practice*		
Primarily inpatient	68	37.16
Primarily outpatient	48	26.23
Equal combination of both	67	36.61
Primarily private	85	46.70
Primarily public	74	40.65
Equal combination of both	23	12.65
Geographical area*		
Metropolitan area	109	62.64
Small community	37	21.26
Rural area	28	16.10

*Numbers in these categories do not total 184 due to lack of responses on questionnaires. Corresponding percents are based on the number of psychiatrists who responded and not the total sample of 184.

trists saw a higher proportion of older patients (13.78 percent) than did either community psychiatrists (8.45 percent) or psychoanalytic psychotherapists (5.68 percent) ($p < .05$ and $p < .01$, respectively, t tests). 2) Overall chi-square value comparing area of special interest and diagnosis was significant ($p < .001$). 3) Overall chi-square comparing area of special interest in psychiatry with degree of interest in older patients was also significant ($p < .05$). Specifically, general psychiatrists reported a greater degree of interest in older patients than community and outpatient psychiatrists and psychoanalytic psychotherapists ($p < .05$).

Most Frequent Diagnoses Reported

The design of the questionnaire provided three blank spaces for respondents to fill in the most frequently seen diagnoses in older people in their practice. Some of the subjects filled in all three, some two, and others only one of the spaces.

The diagnosis most often listed first by the psychiatrists in the sample was depression: 92 respondents listed this first on the questionnaire. Organic brain syndrome was listed first by 44 psychiatrists, making this diagnosis second in frequency. Addictive disorders, anxiety neurosis, and chronic schizophrenia were all mentioned first with approximately equal frequencies that were considerably less than those for depression and organic brain syndrome. When the data were analyzed from another perspective—i.e., the total number of times a particular diagnosis was mentioned—depression was the most frequent (mentioned a total of 151 times), followed by organic brain syndrome (mentioned 143 times), chronic schizophrenia (31 times), addictive disorders (20 times), and anxiety neurosis (15 times).

Psychiatrists' Ages

There was a significant correlation for the entire sample between age of the psychiatrists and percentage of older patients seen ($r = .146$, $p < .05$). When the sample was broken down into various subsamples according to mode of practice or special area of interest (see table 1), most of the correlations were not significant. However, age was positively correlated with number of older patients seen for psychiatrists doing primarily inpatient work ($r = .243$), those working in public settings ($r = .236$), and those who listed geriatrics as a special area of interest ($r = .612$) ($p \leq .05$ for the first two comparisons, no test of significance possible for the last comparison because of small size of subgroup).

Mode of Practice

A comparison was made between mode of treatment (inpatient/outpatient, private/public, rural/urban) and other variables. The following significant relationships were found: 1) Psychiatrists primarily involved in inpatient work saw a higher percentage of older patients than those primarily involved in outpatient work (13.31 percent versus 7.01 percent, $p < .001$, t test). 2) Psychiatrists working in small towns saw a higher percentage of older patients than did psychiatrists working in the metropolitan area ($.05 < p < .1$). 3) Psychiatrists who worked primarily with outpatients favored more comprehensive treatment for the aged than did psychiatrists who worked with inpatients; psychiatrists who worked with inpatients more often saw their preferred role as evaluation or somatic treatment ($p < .001$). 4) Outpatient psychiatrists as compared to inpatient psychiatrists favored the diagnosis of depression over the diagnosis of organic brain syndrome ($p < .001$, chi-square test).

Other Relationships

There were several other significant relationships between the variables I studied. First, psychiatrists who favored treating older patients saw a higher percentage of older patients than those who saw their role as purely evaluative ($p < .02$). Also, the type of treatment favored for older patients was related to optimism about treatment outcome ($p < .001$); and the types of diagnoses more often reported were related to the kind of treatment favored. Specifically, psychiatrists who tended to report more anxiety neurosis favored more comprehensive treatment and those who reported relatively more organic brain syndromes favored evaluation and somatic treatment ($p < .01$).

CONCLUSIONS

As with all data collected in questionnaire studies, one must interpret the findings of this study cautiously. Further, certain imponderables loom large, such as the following: Is the percentage of patients reported actually the percentage seen? When diagnoses are mentioned, are they accurate statements of diagnoses made or do they

represent attitudes of the psychiatrists? When subjects report their degree of optimism, interest, or gratification from older patients, are they operating under a halo effect because they know that the author is interested in geriatric research?

Despite the inherent limitations or imponderables of questionnaire research, I offer the following conclusions:

Depression is the most frequent diagnosis seen in the aged, closely followed by organic brain syndrome. Anxiety neurosis, addictive disorders, and chronic schizophrenia are next, in about equal frequency.

Age is weakly related to the degree of involvement with older patients for inpatient psychiatrists, public psychiatrists, and geriatric psychiatrists. Also, older psychiatrists are more likely to make the diagnosis of anxiety neurosis (a more treatable condition) than are younger psychiatrists; also, younger psychiatrists prefer less involvement (evaluation or somatic treatments) than do older psychiatrists, who favor combinations of treatment including psychotherapy.

General psychiatrists are more interested in older patients than those psychiatrists who have an outpatient orientation (psychoanalytic psychotherapists and community psychiatrists). Also, rural psychiatrists see more older patients than do their colleagues in metropolitan areas. Those psychiatrists who do exclusively outpatient work see fewer older patients but prefer more comprehensive treatment (including psychotherapy).

Finally, for the overall sample, there was a positive relationship among the factors of optimism about treatment outcome, making diagnoses with more favorable prognoses, and preferring treatment rather than mere evaluation for older patients.

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Saliva Lithium Levels: Clinical Applications

BY CARLOS NEU, M.D., ALBERTO DIMASCIO, PH.D., AND DAVID WILLIAMS, PH.D.

The authors note that despite a few reports in the literature indicating that saliva lithium levels could adequately replace serum determinations in monitoring patients being treated with lithium salts, this procedure has not received much clinical application. A study of 20 patients investigated correlations between serum and mixed saliva and parotid fluid lithium levels and documented the reliability of this procedure. The authors suggest that an individual patient's ratio of serum to saliva concentrations should be calculated and used as a constant in the determinations. Patients can collect saliva samples and send them to the laboratory prior to their visits, decreasing the facility's sample collection costs and the patients' inconvenience and discomfort.

LITHIUM CARBONATE IS A psychotropic drug that has received considerable attention from psychopharmacologists in this country and in other parts of the world (1, 2). The use of lithium carbonate in the treatment of the manic phase of bipolar affective disorders and in the prophylaxis of certain types of depression is well established (3–5). When patients are being treated with lithium salts, close supervision is maintained on the serum level of this electrolyte. This is essential because the amount of lithium required to achieve a therapeutic response depends on the concentration of the ion in the serum—which in turn reflects its distribution throughout the body (6)—rather than on the actual amount given per day.

It is recommended that serum levels be obtained frequently (as often as every 48 hours during the first week) at the outset of lithium therapy in order to titrate the drug administration to therapeutic levels (between 1.0 and 1.4 mEq/liter) and to avoid exceeding 1.5 mEq/liter (near toxic level). Serious toxic reactions can develop as a result of poor monitoring (7–9). Once the levels have stabilized, the right oral dose has been found, and the patient exhibits a beneficial response, the serum level need not be monitored more than once every four to six weeks unless toxicity or psychological decompensation occurs.

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The authors would like to thank Mr. John Carpenter of Myerson Laboratories for processing the saliva and blood samples in this study.

A series of serum determinations requires repeated drawing of blood samples. An alternate method of determining lithium level is to assay salivary gland secretions. The clinical application of saliva lithium levels has not found a place in the medical armamentarium, although a few investigators have studied lithium in the secretions of the salivary glands and have found high correlations between saliva and serum lithium levels. In 1903, Good (10) used lithium salts to gain a better understanding of the secretions of the parotid and submaxillary glands. He reported that lithium was secreted in saliva at a higher concentration than is found in plasma. In 1969, Spring and Spirtes (11) and Shopsin and associates (12) published further findings on lithium as a saliva and serum electrolyte. Both groups of researchers reported that the concentration of lithium in saliva was several times higher than the level found in serum. Saliva determination spares the patient frequent venous punctures, lessens the cost of collection equipment (syringes, needles, sterile gauze, etc.), and eliminates the need for the patient to travel to a physician or laboratory to have blood drawn.

Review of the literature we have cited suggests that serum lithium levels could be adequately and reliably replaced by saliva lithium levels, with the advantages stated previously. Based on this information, we did a preliminary study that compared mixed saliva, parotid fluid, and serum lithium concentration in one patient on lithium therapy. Subsequently, we collected data on 19 patients receiving lithium carbonate; in 6 patients the determinations were repeated. Our purpose was to find the correlations between the concentrations of lithium carbonate in the three fluids.

METHOD

Subjects and Procedure

The first patient we studied had been taking lithium carbonate (1250 mg per day) for two years and had been free of symptoms for one year. On the day of the assay, the patient was asked to refrain from taking the morning dose of lithium until he came to the laboratory. He had ingested his last dose of lithium (500 mg) the previous night, approximately 12 hours before the first samples of blood and saliva were taken. Lithium, sodium, potassium, and chloride levels were measured in serum, mixed saliva, and parotid fluid five times during the day: just prior to a 750-mg dose of lithium and 75, 180, 260, and 385 minutes later. The saliva flow rate was also measured at each of these times.

In the second phase of our investigation, the subjects were the first 19 patients on lithium therapy (both in- and outpatients) who came to the chemical analytic laboratory at Boston State Hospital to have their regular serum lithium assay done. In all cases, the subjects took their last dose of lithium carbonate 8 to 10 hours prior to the time of sample collection. Diagnoses and severity of symptoms were not taken into consideration. In addition to having blood samples drawn, these subjects were asked to provide parotid fluid and mixed saliva samples.

Collection and Analysis of Samples

Sample collection. Blood samples of 10 ml were collected without anticoagulant and allowed to clot at room temperature. The serum was separated from the cells within one hour of collection.

Each subject was requested to chew Parafilm M (American Can Co.) for one minute or more, swallowing several times. Then, a saliva rejector with a rubber bulb was used to collect 2 ml of whole saliva. Next, the subject was given a sour lemon candy, a parotid fluid collecting cup was put in place, and 1 ml of parotid fluid was collected into a test tube from the tube attached to the parotid cup (13).

These samples were refrigerated at 4 C overnight and centrifuged. After refrigeration, salivary mucin was readily removed by this method in all but a few samples. In these few instances, mucin was coagulated by heating it briefly in a boiling water bath and then separating it by centrifugation.

Electrolyte analysis. Sodium and potassium were assayed by emission flame photometry and chloride was determined colormetrically (chloride was determined only for the one patient in the preliminary study).

Lithium was estimated by emission flame photometry. Lithium standards for determination of lithium levels in serum were prepared in pooled, normal, lithium-free serum. For saliva and parotid fluid levels, aqueous lithium standards were prepared containing 60 mEq/liter of sodium and 20 mEq/liter of potassium.

RESULTS

Preliminary Study

The analyses of electrolytes in the mixed saliva, parotid fluid, and serum for the patient for whom the samples had been taken at five different times indicated rising and falling levels of lithium concentration over time. The concentration of lithium reached the highest level in the collection taken 75 minutes after ingestion of 750 mg of lithium, both in the serum and parotid fluid (1.25 and 3.00 mEq/liter, respectively), while in the mixed saliva, the level was highest three hours after drug ingestion (3.10 mEq/liter). The correlation coefficients for saliva to serum and parotid fluid to serum were identical (Pearson $r=.94$). A near constant ratio was found between serum and saliva or parotid fluid lithium levels, with an average serum to saliva lithium ratio of 2.35 (SD=.17) and a parotid fluid to serum lithium ratio of 2.20 (SD=.20). (The ratios were similar because the parotid fluid and saliva values were similar.) The constancy of the ratio was also similar for both fluids (variabilities of 7.1 percent and 9.0 percent, respectively). These results also indicated no time delay in the appearance of lithium in serum and in mixed saliva.

The correlation coefficients between lithium and potassium, sodium, and chloride in the two salivary fluids were rather low. In saliva, the correlations were .46, .66, and .41 for sodium, potassium, and chloride, respectively; in parotid fluid, the respective correlations were −.40, .67, and .02. This suggests that the lithium ion behaves independently of the changes of electrolyte concentrations in the salivary glands. Correlations for serum lithium and sodium, potassium, and chloride, respectively, were .80, .89, and .71.

Main Study

Although other electrolytes were measured in the 19 patients studied in this part of our investigation, only lithium levels will be discussed because (as stated previously and confirmed by the low correlations found in this phase of the study), lithium acts independently of the other ions.

The average serum lithium level for all patients was .69 mEq/liter. The averages for saliva and parotid fluid, respectively, were 1.56 and 1.52 mEq/liter. The correlation between the individual parotid fluid and serum lithium levels was .92; for the mixed saliva and serum lithium levels, the correlation was .90. The ratios for saliva to serum lithium and parotid fluid to serum lithium were remarkably similar, with mean ratios of 2.26 (SD=.23) and 2.21 (SD=.20), respectively. The coefficient of variability was 10.2 percent for saliva to serum lithium and 9.0 percent for parotid fluid to serum lithium.

DISCUSSION

Our findings suggest that saliva or parotid fluid lithium levels can be used as reliable indicators in monitoring lithium treatment. High correlations (from .90 to .95) were found between serum and saliva and serum and parotid fluid lithium levels in both phases of the study.

In addition, a highly reproducible constant relationship was noted between the mixed saliva lithium levels and serum level. The average constant was 2.26 ± 10 percent (i.e., saliva lithium divided by 2.26 is equal to serum lithium). Thus the saliva lithium level can be readily converted to the equivalent serum lithium level. The individual ratios of saliva to serum lithium ranged from 1.83 to 2.87, but in the six patients for whom samples were collected and measured twice, the individual scores varied only ± 8.6 percent from the first to the second measurement. Accordingly, we feel that to use saliva most effectively in determining lithium levels, the ratio between saliva and serum lithium levels should be calculated for each individual, and this specific ratio should be used for subsequent determinations for that individual.

The use of saliva lithium determinations has several practical advantages. Patients are spared the discomfort

of repeated venipunctures; the trained technicians required to draw blood are unnecessary because the patient collects the saliva himself; and the need for patients to travel to a laboratory or physician to have blood drawn is eliminated. Saliva can be collected and mailed to a laboratory, and the results can be sent to the doctor prior to the actual visit by the patient. In this way, the drug can be monitored and changes in dosage can be made on the spot. Both acceptance of and ease of treatment with lithium will be facilitated by the use of saliva lithium determinations.

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Renal Tubular Function in Patients on Long-Term Lithium Therapy

BY GEOFFREY W. VIOL, M.B., PAUL GROF, M.D., PH.D., AND LESLEY DAIGLE, R.N.

The authors conducted a study in which 10 patients with recurrent affective disorders who responded completely to long-term lithium therapy but who were otherwise unselected were tested for renal tubular concentrating and acidification ability. Despite frequent symptoms of thirst, polyuria, and nocturia, all patients were able to concentrate urine normally and all showed normal renal tubular acidification ability. A significant correlation was found between erythrocyte lithium concentration and maximum urinary osmolality.

IN RECENT YEARS the administration of lithium salts has achieved increasing acceptance in the treatment of affective disorders. Greater awareness of the side effects of this drug has followed. Polyuria and polydypsia were described as side effects in humans in 1968 (1), and examples of a nephrogenic diabetes insipidus-like syndrome have been reported (2–7) in patients with therapeutic levels of plasma lithium.

In rats, polyuria and polydypsia as well as an inability of the kidneys to concentrate urine in response to vasopressin have been described as symptoms of toxicity at lower plasma lithium concentrations (8). At higher lithium levels, oliguric renal failure has occurred (8).

In humans, lithium overdosage has resulted mainly in central nervous system manifestations; renal involvement has been mild and reversible (9). Polyuria and polydypsia, which have occurred in some patients with therapeutic plasma lithium levels, probably have a different explanation. Experimental studies have suggested interference by lithium with the action of vasopressin (10), possibly by inhibition of vasopressin-sensitive adenyl cyclase (11).

The frequency of the diabetes insipidus-like syndrome in patients on lithium therapy has not been determined,

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The authors wish to thank Dr. K. Fritze and Dr. R. Robertson for the lithium assays.

although one study (12) found that 12 percent of 85 patients excreted over 3 liters of urine in 24 hours.

We investigated renal tubular concentrating ability in 10 patients on lithium therapy selected only by criteria of response to treatment. Because of our experience with one patient (4) we also studied renal tubular acidification function in these patients.

PATIENTS

A large sample of patients maintained on long-term lithium therapy at the Affective Disorders Clinic in Hamilton Psychiatric Hospital was subdivided, according to response to prophylaxis, into complete responders, intermediate responders, and failures. The classification was based on psychiatric criteria alone; the presence of possible side effects such as polyuria or polydypsia was not considered. A group of 32 complete responders (13) was recognized; although these patients had a high risk of further episodes of affective disorders, they developed no relapse during a treatment period exceeding 12 months.

Ten women from the group of complete responders, but otherwise unselected, were able to participate in an intensive outpatient investigation of renal function without undue disturbance to their daily routines. They had been treated with lithium for an average of two years and seven months; their mean age was 50.3 years. The average daily dose of lithium carbonate was 1200 mg (range, 900 to 1500 mg).

METHOD

Lithium concentrations in serum and erythrocytes were measured by flame photometry. After separation of serum and erythrocytes by standard centrifugation techniques, 1-ml samples of both were taken, diluted to 100 ml, refrigerated, and later analyzed by flame-photometric method. A correction for trapped serum was made to the erythrocyte values (14).

Urinary osmolality was measured by freezing-point depression and urine pH was measured with a glass electrode.

Renal tubular concentrating ability was tested by measuring maximum urinary osmolality achieved following an 18-hour water fast and 5 units of subcutaneous vasopressin (Parke-Davis). The normal response, defined elsewhere (15), was greater than 700 mOsm/kg.

Renal tubular acidification ability was tested by measuring minimum urinary pH achieved following an oral dose of ammonium chloride (0.1 g/kg in 1 liter of water). The normal response (16) was below 5.40.

RESULTS

Three patients were found to have a significant bacteriuria (colony count over 100,000) and 1 was hypertensive.

Six patients reported increased daytime thirst and polydypsia on lithium therapy, 6 reported nocturia 2 to 5 times nightly, and 6 reported the need for extra nighttime fluids following lithium therapy.

We obtained the following mean measurements for the 10 patients:

1. Plasma lithium concentration at the time of investigation was 0.76 ± 0.12 mEq/liter (range, 0.61 to 0.91).
2. Erythrocyte lithium concentration was 0.38 ± 0.10 mEq/liter (range, 0.22 to 0.52).
3. Maximum urinary osmolality achieved in the 10 patients was 862 ± 88 mOsm/kg.
4. Minimum urinary pH achieved by the lithium-treated patients was 5.11 ± 0.24.

There was a significant relationship between erythrocyte lithium concentration and maximum urinary osmolality ($r = .67$, $p < .05$, by Spearman rank correlation test).

DISCUSSION

More than half of the 10 patients reported subjective disturbances of thirst and micturition but all were able to concentrate urine normally on formal testing. Increased thirst in rats following lithium treatment in the absence of polyuria and dehydration has been reported (17). Another study (18) demonstrated a significant reduction in concentrating ability in 7 of 10 nonpolyuric patients. Study of a larger group of patients will be necessary to define the incidence of subjective disturbances of water metabolism and of renal concentrating ability; this study has been initiated.

We had earlier observed a patient with defective tubular acidification (4); experimental studies have shown defects of tubular acidification in rats given lithium (18), and a transient reduction in titratable acidity in urine in normal subjects given lithium carbonate has been demonstrated (19). However, in the present study all 10 patients showed normal urinary acidification in response to ammonium chloride ingestion.

The significant correlation between maximum urinary osmolality and erythrocyte lithium concentration is a further indication of the importance of erythrocyte lithium as a guide to tissue effects of lithium (20).

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New Perspectives in Psychiatry in the Veterans Administration

BY JOSEPH J. BAKER, M.D.

In 1972, the mental health services in the Veterans Administration were reorganized in a manner designed to increase the probability of interdisciplinary collaboration. VA hospitals were urged to form multidisciplinary mental health committees to advise on local programs and practices. This "corporate" approach has led to significant changes in the use of staff and in the physical and psychological environment in some hospitals. While it is too early to evaluate the full impact of the changes on patient care, waiting lists have been reduced and length of hospital stay has decreased.

WITHIN THE PAST FOUR YEARS, there have been numerous changes in the structure and function of psychiatric services in the Central Office of the Veterans Administration and, to a somewhat lesser extent, in its treatment facilities. Although too little time has elapsed to permit final evaluation, impressions thus far have been favorable. This paper will describe these changes and discuss some of the effects they have had.

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First, a word about the internal structure of the VA. A large Department of Medicine and Surgery is responsible for all aspects of patient care and for research, education, and medical administration. The department is centrally directed from Washington, D.C., by a chief medical director and his staff. Within this Central Office, each large professional service has its own staff, director, and professional advisory groups. While the professional services do not control funds or exercise authority over operations, they exert considerable influence because of their responsibility for setting professional and technical standards for both personnel and treatment programs throughout the system. They also provide a visible axis about which various training, recruitment, and research activities rotate.

The Mental Health and Behavioral Sciences Service presides over the work of 84 general hospitals offering psychiatric treatment, 28 psychiatric hospitals, 80 mental hygiene clinics, 48 day treatment centers, 37 day hospitals, 53 drug dependence treatment centers, 69 alcoholism treatment centers, and other specialized facilities for persons who are suffering the effects of mental or emotional disorders. These facilities treated 162,000 inpatients in 1972—20,000 more than were treated in 1967. During the same five-year period, the bed capacity and daily census of psychiatric patients dropped by about 25 percent to its present level of approximately 30,000, and outpatient visits increased from 900,000 to 1.6 mil-

lion (1, 2). It can be seen, then, that the VA has made the same philosophical commitment to short-term hospital treatment, rapid turnover of inpatients, and a vast increase in outpatient resources that the rest of American psychiatry has made. In addition, the VA supports hundreds of hospital-based behavioral research projects and each year trains hundreds of residents in psychiatry and doctoral candidates in psychology.

HISTORY OF THE SERVICE

Prior to 1972, the VA Central Office grouped its resource people into a Psychiatry, Neurology, and Psychology Service, which was headed by a psychiatrist. The responsibilities of this service were almost entirely related to the three named disciplines. While there was a degree of collaboration among them, each tended in practice to serve and relate almost exclusively to its counterpart discipline in the hospitals and clinics. The disciplines of nursing, social work, and rehabilitation medicine were represented in the Central Office and in the field by separate but equal services. While this organizational style was adequate for many aspects of the VA's mission, there was a growing feeling that patient care would be considerably enhanced if professional services were grouped in a way that would improve the probability of collaboration in program development.

As a result, in 1970 a Committee on Mental Health and Behavioral Sciences was appointed in the Central Office. This body was asked to study the VA's total mental health effort and to make recommendations for improvement. Headed by the director of the Psychiatry, Neurology, and Pyschology Service, the core group included an executive secretary, two psychiatrists, two psychologists, two social workers, two psychiatric nurses, one neurologist, one physiatrist, and one chaplain. All were highly knowledgeable individuals whose years of experience included significant work in both the clinical and administrative segments of large health bureaucracies. Each had been thoroughly steeped in the traditions and values of his own profession and was actively involved with his national professional societies.

While there was no naive expectation that change would occur easily, the members of this group were unanimous in their enthusiasm for the task and collaborated closely in studying the VA's total clinical case load, its resources, treatment programs, training and research, and the statutes and regulations governing its operation. Each subject was investigated in depth by individuals or subcommittees, who brought their findings and recommendations to the full committee for elaboration and discussion. It quickly became apparent that changes on a pan-professional scale were being considered and that they would not be brought about by a part-time committee; they would call for an unremitting multidisciplinary effort for years to come. Thus, by natural progression over many months the committee arrived at a recommendation that a permanent new service be established in the Central Office and that it be designed to exert its influence in a way that would carry the weight of all the disciplines involved in providing mental health care.

Early in 1972 the recommendations creating the Mental Health and Behavioral Sciences Service in place of the Psychiatry, Neurology, and Psychology Service were approved. The new service was headed by a psychiatrist and included the psychiatry and psychology components of the old service. Neurology became a separate service. Social work, nursing, and rehabilitation medicine each detailed certain individuals to work as full partners in the new service, and the directors of these companion services formed an advisory council to the director of the Mental Health and Behavioral Sciences Service.

ORGANIZATION AND ACTIVITIES OF THE SERVICE

In a new departure, the service was organized into divisions that were subject to multidisciplinary input instead of being the domain of a single discipline. Hence, from the outset the service dealt with its everyday work load in a distinctly different way. Problems relating to treatment programs were referred to the Division of Treatment Services, which included representatives from psychiatry, psychology, social work, nursing, and rehabilitation medicine. (The Program Development Division and the Division of Alcohol and Drug Dependence are similarly multidisciplinary in input.)

Operating in this collective or corporate way, the service was able to focus attention on certain problem areas that had been recognized by individual workers for some time. For example, the physical surroundings in the treatment areas of some hospitals needed much improvement if they were to enhance treatment rather than detract from it. The accomplishments of hospitals that had shown creativity in the use of colors and textures and general improvement of the living space for patients were highlighted in meetings, talks, and by a VA-produced film. In this way, the service was able to stimulate all mental health personnel to look for ways to improve the physical environment at their own facilities.

In a somewhat different way, the service became involved in the VA's attempt to improve the psychological environment in all its hospitals and clinics. Many Viet Nam veterans were outspokenly critical of the VA, which led the Administrator of Veterans Affairs to hold hearings in several VA centers around the country in 1970 and 1971. In these hearings, young veteran patients were encouraged to air their grievances about the system and tell what they thought should be changed. While most of the veterans seemed satisfied with the results of their treatment, there were criticisms related to impersonal and uncaring attitudes in VA hospitals and to regulations and programs that seemed to be geared to an older and different veteran population. As a partial response to this, a long-range program was begun to sensitize hospital workers to the emotional and human needs of people seeking help.

A centralized training course in group and individual

effectiveness that was originally designed for workers in admission areas of VA hospitals was launched in 1972 under the guidance of the Mental Health and Behavioral Sciences Service. The people who went through this training became much more aware of the importance of a caring attitude and the ways in which the presence or absence of this attitude showed in their verbal and nonverbal exchanges with patients. These individuals became trainers of their colleagues when they returned to their hospitals.

The service was also able to focus attention on needed changes in regulations. For example, statutory requirements had for years made it impossible for a veteran with a non-service-connected disability to receive outpatient treatment unless he had first been an inpatient. Whatever its intent, the effect of this regulation was to hospitalize many persons for no other purpose than to make them eligible for outpatient care. The language of a statute that dealt with sharing of VA facilities permitted sharing contracts with community hospitals and medical schools but neglected to mention mental health centers or other freestanding nonhospital mental health facilities. In both of these instances, the new service, because of its multidisciplinary character, was able to mobilize professional opinion and get necessary legislative remedies proposed.

It was recognized that the Mental Health and Behavioral Sciences Service would need to be quite flexible in relating to VA hospitals and clinics. Most of these treatment facilities had been in operation for years and were providing a level of care that was at least comparable to that in other public facilities. For this reason, there was no emergency that required them to reorganize, as the Central Office had done. Instead, the staff of each hospital was encouraged to examine the treatment program in its own setting to see if the program might be made more effective.

At the same time, however, the newly organized Mental Health and Behavioral Sciences Service in the Central Office deliberately began using several techniques designed to demonstrate the effectiveness of the multidisciplinary approach. One of these techniques was the routine use of the multidisciplinary team to make station visits and evaluate mental health programs. Another was the career development workshop for selected mental health professionals from VA hospitals and clinics. Each of these workshops brought to the Central Office a different mixed group of 12 to 15 chiefs of the disciplines related to mental health for three days of informal orientation by the Central Office staff. On a much larger scale, during the last two years there have been three large regional meetings, each of which involved personnel from as many as 35 or 40 hospitals, including chiefs of staff and the chiefs of psychiatry, psychology, rehabilitation medicine, social service, nursing service, chaplaincy, and volunteer services. Participants at these meetings were briefed on multidisciplinary concepts but, more importantly, they spent most of the three days in small group discussions. Each individual met in groups that were multidisciplinary (first with professionals from different hospitals and then with colleagues from his own hospital) and also in groups of single disciplines to discuss the implications of the multidisciplinary approach to institutional mental health programs.

SPREAD EFFECT OF THE MULTIDISCIPLINARY APPROACH

Each of these techniques—the team visit, the career development workshop, and the multidisciplinary conference—has had the effect of modeling the multidisciplinary approach. As a result, many hospitals have established mental health committees composed of chiefs of mental-health-related services. Each committee has tried to define its hospital's mental health mission, its resources, the characteristics of its patient load, and its treatment programs. In most cases, the leadership of the committee has been assigned to the chief of psychiatry, although in some committees, by consensus, this role has fallen to other professionals.

In the hospitals that have gone through this exercise, there has been almost unanimous enthusiasm for the group process and the novel and stimulating experience of being invited to make corporate recommendations that might affect all aspects of the hospital's mental health program. In completing this phase of their mission, committees have been able to agree on various things that might improve services.

Problems of Implementation

Attempts to implement the ideas of the newly created committees I have described have not always been harmonious. Many recommendations have involved new, expanded professional roles and the loosening up of the process of clinical decision making. This might take the form of a recommendation that nonphysicians manage wards, make basic decisions about hospital admission, or coordinate the work of a clinical staff. Each such change involves realignment of roles and delegation of authority that has traditionally been vested in the physician.

Other recommendations have related to team function and have anticipated that team members would help determine team goals and priorities. Where this kind of operation has not previously existed, it has sometimes been difficult to start. The personalities of the team members are crucial. Not surprisingly, a psychiatrist accustomed to having "his" staff carry out his decisions about patients or about the operation of the ward does not easily accept a role that seemingly limits his executive function. Other professionals have equally compelling prerogatives and idealized roles that need to be worked through. Factors like these must be faced and dealt with realistically by the team in order for it to function effectively.

Another variable has been the organizational orientation of the departments of psychiatry in the 89 medical schools affiliated with our hospitals. Many of these schools have adopted a multidisciplinary mode of organization fairly compatible with our own. Other departments, more traditional in their orientation, espouse a

teaching and treatment model dominated rather completely by psychiatry. We have tried to accommodate to both philosophies.

COMMENT

In view of the variety of personal and institutional influences at work, it is perhaps surprising that so many hospitals have been able to make perceptible improvements in their programs by the multidisciplinary approach. Yet it is clear that significant beginnings have been made and that they have not been nearly so disruptive as many professionals feared they might be. In the process, mental health staffs have begun for the first time to show a corporate awareness and concern about long-standing mental health problems facing their hospitals. Furthermore, they have attempted to do something about these problems.

It is too early to evaluate the full impact of these changes on patient care. It is possible, however, to point to some of the effects, such as the abolishment of long-standing lists of patients waiting for admission and treatment and reductions of patient census, and to infer from these effects that patients have been helped. Living areas have been redecorated and rearranged in ways calculated to enhance the patient's comfort, dignity, and self-esteem, and from this it can be inferred that the patient is more likely to improve than he would be in a setting that is ugly and crowded. One can find increasing numbers of VA hospitals where the whole range of mental health treatment services is under the continuous scrutiny of a local multidisciplinary task force, by one title or another, and infer that the many encounters patients have are more likely to be therapeutic because the local staff has contrived ways to make them so.

Although we base our programs on these inferences and others like them, they contain many areas that call for further critical study and evaluation. Psychiatry has had a major part in fostering the multidisciplinary concept and making it work. At this point in history, however, it seems clear that an increasing amount of the energy and time of psychiatrists in leadership roles will be consumed in eliciting cooperative efforts from other people. This is a demanding and often frustrating task, and it is not surprising that some perfectly capable psychiatrists prefer to concentrate on patients and leave team management and coordinating functions to others.

The multidisciplinary team approach is not new, but its promotion in a system the size of the VA has been a novel undertaking. The VA health system provides an ideal laboratory to test this approach because of its size, the great variety of its resources, and the high level of professionalism of its personnel. At this point, we make only modest claims about its superior effectiveness in patient care. At the very least, however, this approach creates an open system that involves everyone in establishing and attaining goals both in the ward and in the hospital as a whole. While this in itself does not make patients better, it seems to us that it creates a posture and setting in which the possibility of patient improvement is greatly enhanced.

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Effects of 5-Hydroxytryptophan on Fragmentation of REM Sleep in Alcoholics

BY VINCENT P. ZARCONE, JR., M.D., AND ERIC HODDES, M.A.

The authors studied the effects of oral loading with 5-HTP on REM fragmentation in a group of alcoholics who were abstinent following acute ethanol withdrawal. Decreased fragmentation was found in the majority of subjects, and those subjects with low baseline REM efficiency (i.e., greater fragmentation) showed more improvement from the drug than did subjects who were less impaired initially. The authors suggest that there is an organic decrement of serotonin during ethanol withdrawal which is partially reversed by 5-HTP loading.

IT APPEARS THAT 5-hydroxytryptophan (5-HTP) could be effective in the treatment of the sleep disorders of alcoholics because of two interrelated factors: the substrate relationship of 5-HTP to serotonin (5-HT) and, relatedly, the considerable disruption of serotonergic sleep regulation that is found in alcoholics (even those who have been abstinent for many weeks). This study compares the administration of 5-HTP to placebo in a group of 12 alcoholics who were abstinent from alcohol following acute ethanol withdrawal.

The role of serotonin in REM and non-REM sleep has been most extensively described by Jouvet (1), who contended that serotonin is a necessary component in the regulation of REM sleep. Serotonin is also necessary for the initiation of non-REM sleep and acts as a primer for the maintenance of REM sleep.

It has been suggested that alcohol ingestion creates an imbalance in serotonergic sleep mechanisms in alcoholics. During drinking periods, alcohol decreases REM sleep. During withdrawal from alcohol, REM sleep is increased but remains fragmented for many days (2). Non-REM slow-wave sleep is also affected by ingestion of alcohol. Terminal sleep during recovery from alcoholic psychosis has been found to be predominantly slow-wave sleep (3), and defects in slow-wave sleep after one to two years of abstinence have been found in alcoholics (4).

We hypothesize that if serotonergic regulation is abnormal in alcoholics, as suggested by the studies cited previously, then loading the system with 5-HTP may help to restore normal sleep. Evidence for the efficacy of 5-HTP in correcting 5-HT imbalance comes from Dement and associates (5). These authors found that 5-HTP abolishes waking ponto-geniculate-occipital spikes, decreases irritability, hallucinations, and abnormal drive-oriented behaviors, and leads to normalized sleep in cats depleted of serotonin by *p*-chlorophenylalanine. Moreover, it has been found that 5-HTP loading leads to normalized sleep after a serotonin-depleted midline raphe nucleus lesion (6, 7).

Alcohol withdrawal syndromes and subsequent drinking bouts may be manifestations of an inability of the serotonergic raphe system to maintain a tonic REM sleep state in which modulation of limbic system regulation of drive-oriented behavior occurs. Admittedly, this hypothesis is highly speculative. However, if it is at all accurate, administration of 5-HTP should decrease abnormalities of REM sleep in alcoholic patients who have sleep abnormalities that persist during abstinence.

SUBJECTS AND METHOD

The design of the study conformed to a 14-night sedative-effectiveness protocol frequently used in sleep research laboratories. However, several additional measures were employed due to our unusual clinical population and the nature of the drug compound.

The subjects were 12 men whose ages ranged from 25 to 52 years (mean=40.7). The number of years these subjects had been drinking ranged from 3 to 34, with a mean of 14.3 years. The subjects had been abstinent for 23 to 133 days before the study began.

The subjects were housed in 24-hour-a-day inpatient wards where they were constantly observed in order to prevent drinking. During the study, each subject slept in a sound- and light-attenuated temperature-controlled room for 14 consecutive nights. All subjects maintained a total dark time in bed of 8 hours (from 10:30 p.m. to 6:30 a.m.).

The first night of the study was used to acclimate the subjects to the laboratory surroundings. Nights 2 to 6 were baseline (placebo) nights, nights 7 to 11 were drug nights, and nights 12 to 14 were recovery (placebo) nights. Each night the subjects received one capsule at 7:30 p.m. and two capsules at 9:00 p.m. On drug nights, each capsule contained 100 mg of 5-HTP; on placebo nights, the capsules contained lactose. Throughout the study, subjects were given bedtime and morning questionnaires to assess the quality of sleep and possible drug side effects. One subject reported abdominal pains on one placebo and one drug night.

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Urine samples were collected from 8 of the 12 subjects following selected drug and placebo nights to ensure that 5-HTP was actually absorbed and metabolized by the body through the oxidating pathway to 5-hydroxyindoleacetic acid (5-HIAA). In each subject, there was a significant increase in excretion of 5-HIAA following drug nights compared to placebo nights ($p=.04$, binomial test).

Each night electrodes were placed on the face, scalp, and chin of each subject according to the standardized sleep montage, and sleep patterns were monitored by polygraphs. The sleep recordings were scored in 30-second epochs by technicians unaware of the experimental manipulations according to the criteria of the standardized sleep scoring manual (8).

RESULTS

Individual and overall means on the conventional sleep variables were calculated and submitted to a matched-sample t test (two-tailed) to compare baseline, drug, and recovery conditions (see table 1). No consistent differences were found at the 95 percent level of confidence for differences between baseline and recovery compared to the drug condition. There was an increase in stage 2 sleep and a decrease in stage 1 sleep in drug periods compared with baseline periods. These small changes persisted into the recovery period.

Although these results suggest that differences were slight for our group of subjects as a whole, we did find obvious drug effects in our subjects on the variable of REM efficiency.

REM efficiency is expressed as a percentage and is calculated by dividing the number of actual minutes of REM sleep by the total number of minutes in the REM periods. (Note that REM periods are defined as any two consecutive epochs of REM sleep separated by 25 minutes or less of other stages.) REM efficiency reflects the degree of REM period fragmentation—lower REM efficiency corresponds to greater REM period fragmentation. Based on normally occurring interruptions of REM sleep, a REM efficiency greater than 90 percent would indicate relatively stable REM periods.

We were particularly interested in those alcoholics with disturbed REM sleep, and we therefore paid close attention to the baseline REM efficiency values of our subjects. We found that 9 of the 12 subjects had REM efficiencies of less than 90 percent. They therefore constituted a suitable sample to use in investigating the effects of 5-HTP in already REM-disturbed subjects.

We submitted the results from these 9 subjects and from the 3 subjects with REM efficiencies greater than 90 percent to matched-sample t tests that compared administration of 5-HTP to baseline and recovery conditions. The results of these tests, shown in table 2, clearly indicate that 5-HTP significantly increased the REM efficiency of the subjects with impaired REM sleep (group 1 in table 2). On the other hand, the 3 subjects who already had high REM efficiencies during baseline (group 2) showed decreased REM efficiencies on the drug, possibly indicating a ceiling effect.

An a priori assumption was made regarding the efficacy of 5-HTP in already REM-disrupted alcoholics after 6 subjects (those designated A–D, J, and K in table 2) had been tested. These results were described at the Serotonin Conference, Palo Alto, Calif., in 1972 (9). After the conference, we tested 6 more of the 12 alcoholic subjects, 5 of whom had basal REM efficiencies of less than 90 percent. We found that REM efficiencies of these 5 subjects improved significantly with 5-HTP ($p \leq .05$). When we pooled the data from the postconference group with that of the other 6 alcoholics, identical or higher lev-

TABLE 1

Comparison of Mean Sleep Variable Data for 12 Alcoholics Before, During, and After Administration of 5-HTP

Item	Condition					
	Baseline		Drug		Recovery	
	Mean	SD	Mean	SD	Mean	SD
Time spent in each stage of sleep (in percents)						
Stage 1*	17.8	4.2	14.3	3.8	14.4	3.8
Stage 2**	45.7	5.1	48.4	5.3	48.5	3.8
Stage 3	9.0	3.4	10.0	2.9	10.3	2.9
Stage 4	5.2	1.8	3.3	2.0	2.9	1.6
REM stage	22.3	4.1	22.7	4.0	22.7	5.4
Other variables (in minutes)						
Sleep latency	22.7	12.7	23.8	13.2	27.6	17.1
Wake time after sleep onset	38.6	19.4	34.4	16.5	39.7	15.6

*Baseline significantly greater than drug ($p<.05$) and recovery ($p<.01$) periods.

**Baseline significantly less than drug and recovery periods (in both cases, $p<.01$).

TABLE 2

Mean REM Efficiencies of 12 Alcoholic Subjects Before, During, and After Administration of 5-HTP, in Percents

Subject*	Condition		
	Baseline	Drug	Recovery
Group 1**			
A	67.6	79.5	72.1
B	76.4	78.4	74.7
C	56.4	61.1	57.2
D	66.9	70.4	66.2
E	85.0	86.7	79.0
F	69.9	83.9	80.7
G	77.1	84.3	83.2
H	68.4	72.8	73.8
I	62.7	70.8	69.9
Group 2			
J	94.4	86.4	85.0
K	97.2	95.5	91.2
L	95.0	90.5	95.1

*Subjects with baseline REM efficiencies below 90 percent are in group 1; those with baseline REM efficiencies above 90 percent are in group 2.

**For group 1, REM efficiency was significantly greater in the drug condition than in baseline ($p \leq .01$) or recovery ($p \leq .05$).

els of significance were found, as can be seen in table 2.

Unfortunately, two subjects (designated as F and G in table 2) disobeyed hospital rules and consumed approximately two quarts of 100 proof ethanol beverage during two days following the baseline recordings. The sleep variables from these subjects resembled baseline values only after two subsequent recording nights. Administration of 5-HTP began the third night after the drinking spree. Given the nature of ethanol withdrawal, the propensity for a lowered REM efficiency in these subjects was very great. Nevertheless, they also demonstrated increased REM efficiency during drug administration.

DISCUSSION

We believe that our findings are consistent with Jouvet's hypothesis that 5-HT is a neurotransmitter which is important for the priming of REM sleep (1). We assume that there may be abnormal regulation of sleep by serotonergic neurons in most alcoholic subjects, which persists during abstinence. This abnormality is partially corrected by loading the system with 5-HTP. While 5-HTP may not act directly to increase the total amount of REM sleep, it may decrease fragmentation within REM periods, thus allowing more normal non-REM/REM cycling and more stabilized REM sleep.

Finally, even though we were impressed with the increase in REM efficiency in the two subjects who went on a short drinking binge, we believe that more research is required to determine whether larger doses of 5-HTP early in withdrawal will reduce REM fragmentation, decrease wake time after sleep onset, decrease stage changes, decrease stage 1 (transition sleep), and increase stage 2 sleep. Another question of interest is whether improved sleep during abstinence will lead to less drinking.

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Reasoned Discourse or a Holy War: Postscript to a Report on ECT

BY FRED H. FRANKEL, M.B.CH.B., D.P.M.

The author points out that both favorable and unfavorable opinions regarding the value of electroconvulsive therapy have become entrenched in the absence of adequate data. These opinions are discussed in relation to the training, experience, and personal orientation of the psychiatrist. The inability of some psychiatrists to tolerate uncertainty is held responsible for their denial of the validity of alternative methods of treatment. The author recommends that psychiatrists tolerate a certain amount of ambiguity and uncertainty: postponing closure may lead to the conclusion that treatment styles (including use of psychotherapy and ECT) are not mutually exclusive.

FOLLOWING THE OBSERVATION that convulsive seizures were at times beneficial in psychiatric illness, Cerletti and Bini (1) in 1938 first used electroconvulsive therapy (ECT) as a means of producing them. The treatment, which is usually repeated on alternate days for some weeks, involves the administration of an electric current (70 to 150 volts) to the brain for .1 to .6 second through electrodes placed over the temples. The procedure has been modified and improved over the years to include the use of general anesthesia and muscle-relaxing drugs, which have made it a relatively safe procedure, with the risk not exceeding that generally encountered with brief anesthesia.

With little but their observations in clinical practice to guide them, psychiatrists have developed different methods of administering ECT, ranging from a maximum number of 8 to 12 treatments over a period of a month to several times that number for many months. Similarly, the selection of ECT as a treatment method varies, with some psychiatrists rarely if ever choosing it and others choosing it fairly consistently. The relationship of the latter group to those who favor the psychotherapeutic approach in treatment captures the essence of the struggle for identity within the psychiatric profession. A consequence has been the righteous indignation of those who virtually never recommend it, offset by a vehement defense by many of those who do.

With the growth of consumer interest and involvement in health care, which had prompted numerous questions about treatment in Massachusetts and elsewhere (especially methods of administering ECT), the Task Force to Study and Recommend Standards for the Administration of ECT in Massachusetts came into existence in January 1972 at the request of Milton Greenblatt, M.D., then Commissioner of Mental Health. The task force of 11 members reviewed the literature for reports of current practice and especially for research data and studied attitudes toward ECT and the methods of administering it from the responses to questionnaires mailed to about 650 psychiatrists and psychiatrists-in-training in Massachusetts. It then attempted to integrate those findings with the opinions of the members of the task force, which included a majority of psychiatrists who use ECT, a child psychiatrist, and others whose major interests were teaching, research, administration, and community mental health.

The task force report (2), which was published early in 1973, included a statement of the purpose of the report, namely to recommend flexible guidelines for the administration of ECT—not to offer rigid requirements. The report drew attention to the dearth of research data, to the small number of respondents (66 of the 650), to the absence of any demonstrable adverse effects following the moderate use of ECT, and to the great need for long-term comparative studies of the effectiveness of different treatment methods in psychiatry. It recommended criteria for selection and methods of procedure; it encouraged further dialogue, study, and publication of the results of using ECT differently; and it called for official statements on ECT by professional bodies of national stature.

In essence, and largely from the accumulated experience of psychiatry, the task force concluded that enough information was available for ECT to be recognized as a necessary and beneficial aspect of psychiatric treatment. It found that there was considerable agreement on the effectiveness of ECT in the treatment of the depressed phase of manic-depressive illness, especially in mid-life or among the elderly, and on the ineffectiveness of ECT in the treatment of character disorders (which may be understood as the root of long-standing maladaptive lifestyles). The members were in agreement that there was no established usefulness in the administration of ECT to children who have not yet reached puberty, and with a struggle, consensus was achieved by the members regarding the use of ECT in depressions considered reactive to life situations. Agreement was also reached on the number of treatments generally considered effective. However, views were *not* unanimous regarding the use of ECT in the treatment of schizophrenia.

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CONTRASTING VIEWS ON ECT

This article, which describes only my own views, addresses areas where unanimity was not achieved and where consensus barely survives. From the responses to the questionnaires, from the deliberations of the task force, from attitudes rapidly uncovered in discussions on ECT, and from events known to have occurred since the publication of the task force report, the prevalence of contradictory opinions regarding these aspects of ECT is inescapable. What is equally apparent is the certainty with which such contradictory viewpoints are defended and the determination with which opposite opinions are dismissed.

Ruling out the extremists on either side, who are vocal but do not constitute a majority (including the occasional psychiatrist whose excessive use of ECT raises several questions, including moral ones), we are still left with a large number of moderate persons whose behavior is proof of their inability or unwillingness to hear both sides of the problem with equal openness. The responses to the Massachusetts questionnaire came mainly from psychiatrists who use ECT or refer patients for it. From our knowledge of the types of practice that prevail in the state, it was concluded that the vast majority of those who did not respond had insufficient knowledge of or exposure to ECT, were unable to support their unfavorable attitudes, or were uninterested.

Although regarded by many psychiatrists and mental health professionals as a balanced and realistic appraisal of the status of ECT, the report (referred to in some quarters as the Massachusetts Guidelines) has been quoted by others as leverage to accomplish ends at odds with its wording. Well-meaning agencies and professionals have used the report in their efforts to establish regulations requiring committee approval for the use of ECT in every case, a list of diagnoses for which ECT is prohibited, and the control of the use of ECT by statute. These efforts were justified by their proponents on the basis of sections of the report taken out of context and interpreted in a manner different from the report's expressed purpose. Other professionals, despite their regard for the caliber of the task force members with opinions different from their own, have been tempted to describe as malpractice those methods of treatment for schizophrenia about which they disagree.

EXPLANATIONS FOR DISAGREEMENT

It is astonishing to me that, in the absence of convincing data, large groups of fully trained professionals approach the practice of their calling at right angles to each other, displaying vehemence in support of their own positions that increases in proportion to the earnestness of their critics. It is this phenomenon—the exclusion of or inability to entertain a viewpoint different from one's own—that compels us to try to fathom it. Of course it would be unfair to conclude that all psychiatrists, in one way or another, stand at daggers drawn. For the most part they work in individual practices or in association with hospitals and agencies having an orientation similar to their own, and they reinforce their attitudes by discussing clinical issues almost solely with peers of similar persuasion. Although the gap may have narrowed among some of the other therapies directed at individuals, groups, and families, or involving methods dependent on deconditioning, psychodynamic insight, medication, and community programs, attitudes regarding ECT have remained singularly entrenched. Most psychiatrists either believe in the value of ECT and administer it, or they avoid it almost entirely. It is only in rare instances that they refer a patient to a colleague whose practice is different from their own for an evaluation for alternative treatment; this may be more frequent in institutions where a multidisciplinary approach is encouraged. How may we attempt to understand these staunch beliefs, which endure without any convincing long-term comparative studies of the effectiveness of ECT, psychotherapy, medication, milieu factors, or combinations of these methods in the treatment of conditions like schizophrenia or complicated depression?

Three categories of reasons seem likely to explain this special behavior associated with ECT. The first is the often quoted personal investment of time and effort (not to mention financial resources) to master and then have the opportunity to practice special skills. However, if we adhere too closely to this as the main factor motivating the behavior, we lose sight of the fact that many psychiatrists in training have had an opportunity early in their careers to choose between the psychodynamic and the more biologically oriented approaches and have responded more to the qualities of one than to the other, even before receiving much instruction.

This leads to the second category, which probably reflects the personality qualities of the trainees (hinted at above). Those sympathetic to reflection and introspection, who are psychologically minded and not primarily people of action, are probably attracted to the psychodynamic style of treating psychiatric illness. By training—but possibly also by choice—such individuals become reluctant to engage in physical contact with the patient. Those favoring the biological approach seem eager to apply the training acquired in medicine and surgery, which not only encourages but demands bodily contact with the patient. Nonmedical mental health workers include this style in the term "medical model." Because of their own interests, training, and experience the majority of them tend to favor individual or group psychotherapy or environmental programs.

The third category includes the reasons that flow from the reinforcement of successful clinical experience. Both those who use ECT and those who do not are thanked by grateful patients who appear to have improved. Some patients yearn for understanding or insight; others prefer more immediate relief. Whatever the criteria of improvement used by patients and their families, the reported success of a treatment reinforces the professional's belief in himself and in his style of practice.

SIMILARITY TO RELIGIOUS BIAS

In whichever way these reasons exist or combine, they seem capable of precipitating an effective mechanism for defense against uncertainty—namely, that of denial. The move to closure without all the clues and the commitment to one of two seemingly mutually exclusive choices are hallmarks of such a defense. The fervor with which the belief systems are subsequently upheld is strongly reminiscent of religious bias.

My purpose in this report is to encourage patience with, and a tolerance for, ambiguity and uncertainty. This is especially pertinent in the study of the behavioral sciences, where, at present, we are more dependent for our conclusions on accumulated experience and knowledge than on reason and logic. Postponing closure, with its denial of alternatives, may well lead to the discovery that treatment styles are not mutually exclusive, that psychotherapy and ECT may both appropriately be combined with other treatment methods, and that only by comparing the results of different methods in a well-planned prospective study will a logical preference be feasible.

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How To Avoid Taking the Boards but Save Face

BY DANIEL Y. PATTERSON, M.D.

The author presents several options for other psychiatrists who wish to avoid taking board examinations and still save face. Although the author states that none of these worked for him, he wishes to present his suggestions to others in the field.

BOARD CERTIFICATION (and, unfortunately, recertification) will become increasingly important in the future. Position appointments and eligibility to practice (or to be paid for practice) may soon depend on board certification. Two years ago, after two and a half years in an administrative post with the federal government, I was appointed chief of psychiatry of a large prepaid multispecialty group practice. The chiefs of the other medical services, already board certified in their medical specialties, had made the assumption that I would "get the boards out of the way" in the coming year. Although board eligible, I had not seen a patient for what seemed a very long time. The other department heads talked about "getting your boards" as if it were as easy as getting your state medical license by reciprocity. What if I failed the boards? How embarrassing! I began to ask myself the question, "How could I avoid taking the boards but save face?"

My initial thoughts were temporizing measures—illness in the family, taking boards was too expensive, my new job was too time-consuming, etc. Although these reprieves could be used in parallel or sequentially, I knew they would run out in time. I began to search for a more permanent solution to my problem. After much deep thought (and conniving) I came up with a variety of options (I learned that word when I was a bureaucrat).

OPTION 1: PRESTIGIOUS RESIDENCY: "WHO CAN EXAMINE ME?"

Why not? I had trained at Johns Hopkins Hospital, where Adolph Meyer's ghost still stalks the halls. Hopkins-trained internists had taken this tack in years past. Why couldn't it work for me? But this approach seemed too "uppity."

OPTION 2: SCATHING ATTACK ON THE VALIDITY OF THE BOARD EXAM

If only I had been farsighted enough to coauthor the paper on the pseudo-regulation of American psychiatry written by two of my friends (1)! Even if I hadn't worked

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on the paper, they might have acknowledged my "help" if I had asked nicely. Having been coauthor or "honorably mentioned," I would have gone on record as to the inauthenticity of the present certification procedure and could have claimed that the present board would be "out to get me" were I to take the exam. My one major reservation about choosing this course was that the American Board of Psychiatry and Neurology might institute the changes suggested in the article; then where would I be? The proposed changes seemed unrealistic enough (e.g., "Other human service professionals and lay advocates should be added as members of the American Board of Psychiatry and Neurology ...." and "establishment of proficiency standards for psychiatric practice ...." [1, p. 661]). A few years ago I would have felt safe, but lately there have been changes in the American Psychiatric Association that no one would have predicted, haven't there? Who knows what might happen in the next few years? I discarded this option as being too risky.

OPTION 3: PSYCHOANALYTIC PRACTICE OR ADMINISTRATIVE PSYCHIATRY DODGE

Friends of mine who were in analytic training were able to dismiss the boards as "irrelevant." Why couldn't my interest and career choice (administration) allow me the same dodge? Unfortunately, I was up to my ears in clinical practice and would be for years to come. What was worse, the other chiefs of departments where I practiced were into a kind of clinical machismo that said "Not only are we good administrators, but we are the best [insert internist, pediatrician, obstetrician, etc.] in the department." I knew this option would never work for me. At this point I was getting desperate. I strained harder for a workable solution.

OPTION 4: PERMANENT INELIGIBILITY FOR BOARDS ON A TECHNICALITY

I rushed to examine the requirements for board eligibility. Could I find a technicality that would make me permanently ineligible for boards without additional training? No one would expect me to give up my present post to go back to get further training. Since I had already applied and been declared eligible for boards, it would be somewhat embarrassing to bring to the board's attention the technicality that made me ineligible, but I no longer had any pride. Even after careful review and rereview I could not come up with a solid case for ineligibility. I had some arguments but nothing "hard" enough to make the board reverse itself. Anyway, choosing this course of action was like shooting off one's big toe to avoid the draft. Who wants to walk around a professional cripple all his life?

OPTION 5: ECCENTRIC OR LIBERAL PROTEST

Since psychiatrists seem to have a societal license to be eccentric, could that not be adequate grounds for refusing to take boards? Alas, I was not the eccentric type. I have never had a beard or long hair. I even practice in a tie and business suit. Could my not taking the boards be a part of a politically activist or counterculture protest? Again, I'm just not a symbolic protester. I paid my income tax even during the Viet Nam War. Although I consider myself liberally inclined and work for issues I believe in, I've never demonstrated or gone on strike. I would even eat nonunion lettuce and grapes if it would be embarrassing not to.

NO MORE OPTIONS

Having exhausted my options, I resigned myself to my fate. Realizing, however, that other psychiatrists face this same dilemma, I felt it would be a contribution "to the literature" to document the options available to those who want to know how to avoid taking the boards and save face.

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The *Curandero*'s Apprentice: A Therapeutic Integration of Folk and Medical Healing

BY JEROLD J. KREISMAN, M.D.

The author discusses alternative methods for dealing with folk illness in psychotherapy. Two case reports are presented that describe psychotic Mexican-American patients who were successfully treated with an approach that integrated curanderismo, *the Hispanic concept of healing, and traditional therapy. The author discusses ethical aspects of this integrated approach and suggests that cultural considerations can be successfully incorporated into a treatment plan of optimum benefit for the individual patient.*

MODERN PSYCHIATRY must extend treatment to people of many different backgrounds. However, such assistance often fails to acknowledge and work within an individual's cultural frame of reference. The Hispanic population is Denver's largest minority group, and, despite acculturation, the Hispanic culture is pervasive in many areas, particularly the concept of illness (1, 2). Unfortunately, there is little integration of these unique cultural considerations into a definitive treatment plan for Spanish-speaking patients.

This paper describes two cases involving Mexican-American schizophrenic patients in which conventional therapy was seriously stalled until treatment was adapted to the patients' culturally bound concept of their illness. The therapy was modified to conform appropriately to a model of *curanderismo*, the Hispanic concept of healing (2–4).

THE MEXICAN-AMERICAN FAMILY AND THE CURANDERO

As others have noted (1–4), the Mexican-American family is typically a tightly knit unit; distrust of agencies outside this unit prevails. Since illness may be perceived as a hereditary defect, the family strives to determine that a member's illness is due to external, extrafamilial factors, often seeking the services of a *curandero* (healer), who will support such an etiology. The *curandero* is a very religious and highly respected member of the community who retains many of the customs of Mexico, maintaining cultural bonds for even the acculturated Mexican-American.

Case Reports

Case 1. J.S., a 31-year-old Mexican-American woman, was brought to the hospital by the police because of disorganized, bizarre speech and behavior. She had been hospitalized twice previously with a diagnosis of paranoid schizophrenia. At the time of admission, the patient was confused, suspicious, resistive, and actively hallucinating.

On the ward, she was given trifluoperazine and she partially reintegrated over a two-week period. Although oriented and exhibiting more appropriate behavior, she remained withdrawn and secretive. She vaguely but inconsistently acknowledged auditory hallucinations and continued her reticence in psychotherapy, exhibiting no insight.

After several weeks of stalled therapy, the suggestion was introduced that she might be *embrujada* (bewitched). She responded with great affect and relief, confirming the suggestion and expressing surprise at the therapist's grasp of the problem. At that point, the therapist described a course of *curanderismo*, relating that he had worked with a *curandera* who had granted him use of her herbs in combination with a prescribed ritualistic regimen designed for victims of *embrujada*. The therapy included prayer, isolation, and personal deprivation, in combination with the prescribed herbs—actually doxepin hydrochloride (Sinequan).

She described immediate improvement when the course of *curanderismo* was added to the regimen and has functioned well since discharge. There has been a marked deemphasis of the etiological significance of the folk illness, although upon direct questioning she confirms that she is no longer troubled by "spirits." More important, immediately following discussion of her concept of her illness, the patient for the first time began openly revealing and discussing pertinent parts of her history and important intrapersonal conflicts.

A later difficulty involving the transfer of her case to an outpatient therapist was resolved by a joint meeting with the patient and the two therapists, during which the new therapist expressed understanding of the patient's concept of her illness.

Case 2. D.M., a 22-year-old unmarried Mexican-American woman, was admitted for the first time to the hospital with psychotic behavior one week after the birth of her first child. At the time of admission, she appeared grossly psychotic and suspicious, divulging little information. She was given haloperidol and improved within several days, although she retained a markedly flat affect.

She was discharged after two weeks in the hospital, but was readmitted one week later with the recurrence of symptoms. At the time of her readmission she also exhibited significant signs of depression. After antidepressants were added to the haloperidol regimen, she again partially recompensated, but the flat and inappropriate affect persisted. Her family clamored loudly for

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The author wishes to express his appreciation to the staff of the psychiatric unit, Denver General Hospital, and to Stephen Dilts, M.D., for encouragement and suggestions in the preparation of this paper.

her release, simultaneously expressing dissatisfaction with the hospital's treatment and the conviction that the patient was well enough to return home. The patient continued to be very resistant and the therapy was stalled.

At this point, the patient told a Mexican-American staff member about the possibility that a hospitalized patient might actually be "hexed." At a subsequent interview, the therapist remarked that he had observed a similar case in which a patient had felt she was *embrujada*. The patient responded enthusiastically to this suggestion, acknowledging that her mother had been trying to find a *curandero* for her.

She eagerly responded to a proposal to utilize the *curandero*'s herbs in the hospital and rigorously prepared herself for the ordeal with prayer and isolation. She also devised specific criteria by which she could judge when she was no longer *embrujada*. Her improvement in the hospital continued but, although acknowledging she was regaining her health, she insisted that only after receiving the *curandero*'s magic would she be totally cured.

Prior to the initiation of the hospital *curanderismo*, the patient, while on a pass, was taken by her mother to a local *curandera* who administered "medicine." She returned to the hospital complaining of xerostomia, blurred vision, tremulousness, and the return of persecutory auditory hallucinations. She also exhibited nystagmus, mydriasis, and tachycardia. As her symptoms persisted over the next few days, the patient requested the hospital *curandero*'s herbs, which she felt could counteract the local healer's drug. Within one day after initiation of the regimen (doxepin hydrochloride), her symptoms disappeared and she had also fulfilled her own criteria that indicated she was free of *embrujada*.

Over the next several weeks the patient began to progress significantly in psychotherapy and a firm rapport was solidified with her as well as with her previously hostile family. However, she retained a markedly flat and often inappropriate affect, failing to regain her state of health before her encounter with the local *curandera*. A course of electroconvulsive treatment was eventually initiated, and the patient responded exceptionally well. She has regained her premorbid status, retaining her previous job and assuming mothering responsibility for her child.

COMMENT

Psychiatric treatment often displays little regard for an individual's cultural frame of reference. The two cases I have described represent an attempt to actively integrate modern mental health resources within a framework of a Hispanic concept of folk illness. Such an approach in this particular culture has not been extensively investigated, although the success of folk healers is well documented (3–6).

A recent article (7) did describe an attempt to treat 15 cases of *embrujada* within the appropriate cultural framework. The authors stated that 12 of their 15 patients were markedly improved when treatment included the suggestion that the medication was derived from the *curandero*'s herbs of northern Mexico. In these cases, however, the subject of *embrujada* was not openly discussed. Further, the 3 failures in this study were the 3 psychotic patients. Kiev (3) has also observed that *curanderismo* tends to be less successful in psychotic patients. However, in the two cases I have described, both schizophrenic patients responded well to a *curanderismo* regimen in conjunction with somatic treatment and psychotherapy. Such an approach may indeed be a useful—perhaps even necessary—supplement in the treatment of psychotic patients of Hispanic backgrounds.

TREATING FOLK ILLNESS

Recognizing the Problem

A major problem in dealing with folk illness is recognizing when this concept is a significant factor in the malady. It may not be necessary to explore this ground unless the patient's conflicting view of his illness interferes with therapy. However, as Casper and Philippus (7) emphasized, it is unusual for the Mexican-American patient to volunteer to the Anglo therapist the belief that he is *embrujada*, although he may well respond enthusiastically to such a suggestion from the psychiatric worker. Therefore, the therapist must be aware of subtle signs which indicate that a patient's concept of cultural illness is conflicting with a traditional therapeutic program.

As the case reports I have presented illustrate, patients in whom such a conflict exists may display mistrust and evasiveness, often as a reflection of their inability to translate culturally defined concepts of disease to a socioculturally distant therapist.

Another possible indication of the existence of a problem is the achievement of a plateau stage wherein the patient fails to progress following initial improvement on medication. Although better integrated, he may display significant discomfort in psychotherapy sessions. At the first sign of improvement, the patient may demand discharge, despite an awareness that he is not yet well. This demand may be the patient's expression of his conviction that he must seek a *curandero* for definitive treatment.

Probably the most significant indicator in the recognition of folk illness as a significant factor in a patient's psychopathology is the reaction of the family. They may demand the patient's release, expressing a desire to take the patient to their private doctor and criticizing the hospital care. This usually reflects the family's anxiety over the patient's illness and their conviction that he will not regain his health until the *curandero* intervenes.

Approaches to Treatment

If the therapist feels that folk illness is a significant factor in a patient's illness, he is faced with the dilemma of how best to confront this issue. Several alternatives are available and may be referred to as approaches that ignore, compete, cooperate, or integrate.

The first approach, the most obvious as well as the most frequently used, is to totally ignore the patient's concept of his disease, dealing only with a medically oriented model. The prevalence of this attitude stems primarily from ignorance of an individual patient's frame of reference. Although this approach may be acceptable in some cases, it is probable that few patients are best treated by completely ignoring their cultural biases.

The second approach is to acknowledge and discuss the patient's concept of his illness but to compete against it. The traditional medical view of disease is offered as the one true, rational construct; the patient's own culturally based understanding is denigrated. Although some patients may respond to an outsider's admonitions that the folk explanation of illness is nonrational, logical argument cannot pretend to negate an individual's lifetime training.

A third alternative is the cooperative approach, in which the therapist benignly accepts the patient's concept of his illness and avoids competition with this belief. Here, traditional psychiatric care and *curanderismo* maintain a kind of separate but equal status. The patient's realization that the Anglo doctor may truly appreciate the problem in its proper context may encourage him to open up further in therapy.

Unfortunately, however, this approach may require an impossible degree of rapprochement between folk and medical sciences. In legitimizing but not specifically using the folk interpretation of illness, the psychiatric worker implicitly accepts the role of the outside *curandero* in the therapy program. Except in the rare instance in which the therapist and the *curandero* can work cooperatively, introduction of the *curandero* will usually interfere with treatment.

In the approach that stresses integration, the therapist may not only accept the patient's cultural beliefs but may encourage their expression, actively seeking to integrate his therapeutic regimen within a framework consistent with the patient's understnding. The therapeusis is employed within the appropriate cultural bias, but unpredictable outside forces are not introduced. Folk and scientific treatments are equal but not separate in this approach; they are integrated under the total control of the therapist. Such a technique was utilized with success in the two cases I have cited.

Advantages of Introducing Curanderismo

Dealing directly with a patient's cultural view of his illness may complicate therapy by introducing many new variables. However, such confrontation can have a very positive effect on the treatment. The most obvious advantage is the increase in rapport and trust within a therapeutic alliance. The therapist demonstrates a true grasp of the patient's anguish within the patient's own frame of reference. In both of the cases I have described, a working therapeutic alliance was not established until the therapist clearly demonstrated this understanding. Interestingly, however, once this area was approached openly, the entire topic of folk illness ceased being an issue, as Casper and Philippus (7) have also noted.

Another important advantage of this technique is the enlistment of family involvement and support. In case 2, the previously hostile family attitude abruptly changed following the therapist's acceptance of the concept of *embrujada* and his successful use of *curanderismo*. Indeed, this confidence in the psychiatrist encouraged the family to contact him when the patient suffered the ill effects of the local *curandera*'s herbs. The family revealed that without this relationship, they would have declined to contact a resource within the medical system at that critical time. The enlistment of family support in a society in which this unit is a primary force is essential in insuring cooperation in both short- and long-term treatment plans. This fact is especially well understood by the *curandero*, whose initial energies in treatment are directed toward achieving family support and cooperation (3).

Ethical Issues

An important issue raised by this integrated approach to psychiatric treatment in a culturally distinct minority population is that of morality. What are the ethics of a non-Hispanic therapist invoking Hispanic ritual in his treatment plan? By unconditionally accepting the patient's precepts, is he fostering a delusional system that he should be attempting to alter? One might argue that the folk concept of illness is not a true pathological delusion, but rather a culturally developed, culturally acceptable belief that is as resistant to challenge as is that of a devoutly religious individual who claims to hear the voice of God.

Perhaps a more difficult issue involves the therapist's role as *curandero*. In one view, he is working within a patient's cultural frame of reference, exploiting a position of authority in achieving a suggested placebo effect. But does he cross the nebulous boundary between firm suggestion and outright fraud? It might be argued that a therapist using this technique differs little from a general practitioner offering subtherapeutic doses of a minor tranquilizer to his chronically somatizing patient together with strong incantations that the medication will cure him. In this country's cultural setting, in which pills can magically cure any ailment, such a physician is merely fulfilling a culturally defined role as healer. Nevertheless, it is certainly presumptuous for an Anglo therapist to interject himself into the Mexican-American cultural system, a system he cannot fully appreciate. And yet, perhaps this does not entirely preclude his working in such an area, just as a male obstetrician can still empathize with a woman's labor and offer valuable assistance to her at that time.

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LETTERS TO THE EDITOR

On the Evolution of Neurotic Maladaptations

SIR: I would like to take issue with the conclusions A.D. Jonas, M.D., and D.F. Jonas expressed in their article "The Evolutionary Mechanisms of Neurotic Behavior" (June 1974 issue). Having referred to the relatively helpless state of the human infant, they see the "slowing of developmental processes" in man as contributing to man's intellectual growth and opening the way to the "emergence of phylogenetically early responses." They conclude that "many of the maladaptive behavior patterns labeled as neurotic result from man's retention of archaic responses." Impressed by the maladaptive components of neurotic behavior, they do not see them as fulfilling any biological function. In order to account for the presence of neurotic maladaptations they label them as "archaic responses."

My first criticism is that the authors have overlooked the work of Price (1), who used ethology to define one biological function for human neurotic reactions. He described such reactions as having evolved as the "yielding component of ritual agonistic behaviour," i.e., avoiding violent confrontation in competitive situations aided the survival of the individuals involved and therefore of the race.

My criticism of the Jonases' conclusions stems mainly from my belief that an important biological function for human neurosis can be defined, i.e., promoting man's intellectual growth. Maladaptive behaviors labeled as neurotic reflect and in turn contribute to the human organism's maladaptation to his environment. Neurotic maladaptation is therefore a vicious circle: the impact of small genetic differences in viability between competing organisms may be magnified and the initial difference in viability between them may be greatly increased.

For example, an individual who has a slight genetic disadvantage in relation to a competing person is likely to be the loser more often and thus more prone to develop feelings of inadequacy and frustration and neurotic maladaptive behavior patterns. If these humans were competing in a primitive environment, the increased neurotic behavior of the less successful competitor might significantly impair that individual's viability.

Neurotic maladaptation could therefore be viewed as an evolutionary mechanism that greatly accelerated the evolution of the human species during the pretechnological age. Although it may have had a negative impact at the level of the individual, it would have had a positive impact on the evolution of the human species by accelerating the process of natural selection. We do not directly inherit neurotic traits, but all of us have the potential to develop neurotic symptoms under adverse circumstances (2).

In view of the fact that chance mutations that have a favorable influence on man's intelligence are likely to have minuscule effects, the magnification of impact (resulting from increased neurotic maladaptation of lesser endowed competitors) has probably contributed significantly to man's intellectual development.

Price's hypothesis and my own are not necessarily mutually exclusive. It could be argued that neurotic individuals who have experienced frequent failures might be more submissive or yielding.

In summary, my argument is that human neurotic reactions may have had a much more comprehensive biological function in the pretechnological era of human evolution than has been suggested.

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The Jonases Reply

SIR: When one deals with a complex subject consisting of many subsystems, one has to recognize it as such. A failure to do so results in a view of the complex subject as admitting only one truth.

Dr. Sloman deals with an end result or effect of an emerging neurotic response as though it were a totality. The subject of our paper was a subsystem, i.e., the mechanisms that provide a variety of channels, into one or some of which an environmental stimulus enters, is elaborated, and emerges as a psychological and/or somatic response.

Dr. Sloman proposes that neurotic responses are adaptive in that they promote overcompensation in some individuals. We have no quarrel with this point of view. In fact, we have written extensively along these lines (1). However, when compensatory or displacement mechanisms lead to physical disability, shortening of life, sudden death (in cases of cardiac involvement), or behavioral malfunctions promoting serious social problems, we would seriously question any phylogenetically adaptive value.

We certainly agree with Dr. Sloman about the value of Price's work, with which we are familiar. Indeed, Dr. Price is a good friend and we have had many discussions with him on this topic. However, like Dr. Sloman, Dr. Price deals with an outcome and not with the mechanism that gives it form.

We believe that an understanding of those evolutionary mechanisms which promote psychological consequences gives a sounder theoretical basis for psychodynamic formulations, places etiological factors into a coherent scheme, and ultimately must result in more effective therapeutic measures.

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On the *Journal* and the Moon

SIR: The appearance of "The Questionable Relationship Between Homicides and the Lunar Cycle" by Alex D. Pokorny, M.D., and Joseph Jachimczyk, M.D. (July 1974 issue) does a great disservice to this journal. Perhaps because of the scarcity of quantifiable data in the behavioral sciences, we psychiatrists are too attracted to reports that include graphs, charts, and statistics, especially when embellished with chi-square values and statements of statistical significance or the lack thereof.

The issue of proving or disproving that homicide or lunacy has anything to do with the moon is dignified greatly by the appearance of this study in the official publication of the American Psychiatric Association. Counting this article, *The American Journal of Psychiatry* can now claim to have published a total of five papers and one letter to the editor addressed to this ludicrous issue (1–5). Furthermore, the appearance of this article suggests to the profession that this is a reasonable area of research interest. Apparently some people have taken the old Lon Chaney, Jr., films seriously.

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NORMAN B. LEVY, M.D.
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Dr. Pokorny Replies

SIR: I cannot speak for the general editorial policy of the *Journal* or for the content or emphasis of Dr. Levy's first four references. I would state, however, that there is a strong interest in the topic of our paper; many laymen and professionals seem fascinated by it. Furthermore, if there is a popular belief that moon phases influence behavior, such relationships may occur, even though they are mediated by psychological rather than physical influences.

The reports in which I have been involved have been consistently negative concerning the role of the moon in mental disorders. I believe Dr. Levy and I are on the same side; I too question the relationship between moon phases and such gross human events as homicide or suicide. The work of our group has consisted of a series of unsuccessful attempts to replicate a number of positive reports. In my opinion it is better to do this with data—including graphs, charts, and statistics—than to simply dismiss the question as "this ludicrous issue."

ALEX D. POKORNY, M.D.
Houston, Tex.

Person-to-Person Therapy

SIR: Every once in a while I read something in the pages of this journal so incredible that I have to respond. A case in point is the letter from Myron F. Weiner, M.D. ("Self-Disclosure by the Therapist," August 1974 issue) concerning Leston L. Havens' article "The Existential Use of the Self" (January 1974 issue).

If I understand him correctly, Dr. Weiner says that therapists must be careful with the technique of using the self, that there are definite indications and contraindications. He says:

> The chief indication for the therapist to reveal his feelings is when the treatment need of the patient requires that the therapist relate as a feeling person. This occurs at certain stages of the treatment of many types of patients but *only when there is an adequate bond between patient and therapist* [italics mine] . . . . The average patient who is recovering from an emotional upset has little need to experience his therapist as a person if he has been able to make use of suggestions, environmental manipulation, or medication.

In my opinion, Dr. Weiner's statement is backwards. I think such techniques as silence, objectivity, and withholding are fine if an adequate bond has already been established, and that the therapist relating to his patient as a person is the only way to establish such a bond.

I would feel foolish even saying this, since it seems so obvious, but for the fact that the opposite is taught as dogma in so many mental health training programs. My experience has been that the only thing that really helps a person experiencing emotional crisis is another person letting him know that he has been there and understands. The next best thing is someone who, although he has not been there, is willing to be honest about where he is, e.g., wanting to help but not knowing how.

I also disagree with the idea that only people experiencing emotional crisis want to register another person as real. If I have a new idea, I want to know how it strikes someone else. I do not want to share the idea with someone who will simply look objective and mask unspoken feelings.

Why do psychiatrists think it is wrong to act like human beings? If we really know more about mental health than most people, we do not have to worry; it will become obvious to our patients. Is Dr. Weiner's experience so different from mine that he really prefers suggestions, environmental manipulation, and medication to the honest clout of a real person?

Finally, I found it very disturbing that Dr. Havens, whose article I really liked, says in his response to Dr. Weiner that he was not advocating the use of the technique. Where is a young psychiatrist trying to be a human being to look for guidance?

PETER A. ROEMER, M.D.
Silver Spring, Md.

Dr. Weiner Replies

SIR: Dr. Roemer understands me correctly. What the ordinary psychiatric patient needs is a neutral professional helper, not an exposure to the feelings of his doctor.

The doctor must have sufficient acquaintance with his patient and with himself to calculate (that's right, calculate) the probable impact of his real self on the patient. The "honest clout of a real person" may be exactly that: a good, hard clout that relieves the therapist and leaves the patient to cope with the therapist's feelings as well as his own.

A young psychiatrist trying to be a human being should first look outside his practice, to his family and friends. If he is un-

able to be a person in this area of life, he should consider therapy for himself. Becoming a patient in a therapy group is an excellent means by which a therapist can obtain interpersonal feedback.

Psychiatrists do not think it is wrong to act like human beings. Most of us do. But we do not lead with our humanness; we lead with our experience. Being human with patients, like displaying one's sense of humor (1), comes later, after both therapist and patient are certain that the patient is willing and able to get to know his therapist. Patients are not usually so fragile that they will crumble under an awareness of the therapist as a person, but the therapist can help set up unresolvable resistances by early disclosures of his prejudices, weaknesses, or needs (2). This kind of disclosure simply distracts from the real business of therapy—the patient's getting to know himself.

Being neutral in the early stages of therapy and even when the patient is demanding "realness" from the therapist is not always a cop-out. It is the best assurance the therapist can have that he is not exploiting the patient for his own emotional needs. The therapist's neutrality (not impassiveness) can help to get across two important points: that the patient needs to turn to someone other than the therapist for satisfaction of the bulk of his emotional needs and that the therapist is entitled to his own privacy.

Neutrality is the best way for the therapist to avoid exploitation of the patient for his own emotional needs and gives the patient less encouragement to demand that the therapist meet, rather than help him understand, his own emotional needs.

To sum up, the therapist owes a patient his professional expertise, not himself (3).

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MYRON F. WEINER, M.D.
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Dr. Havens Replies

SIR: The fact that there are forces in clinical situations that require careful handling, especially transference and countertransference, coupled with the fact that "acting like a human being" does not necessarily mean acting like a mature or even a sensible one, makes technical advice necessary. In other words, a general formula such as "act like a human being" is as bad as its opposite, "never act like a human being." We have to have technical guidelines, even though I do not like the word "technique" either. Perhaps it would be better to say that we all occasionally need examination and adjustment of our perspectives.

I honestly believe that, beyond certain spontaneous intuitions and feelings, we do not know a great deal about when to act in a less than strictly professional manner in clinical situations. In my article I worked toward a description of the method or perspective of existential psychiatry because only by defining, applying, and studying it can we refine our knowledge of when to use it. That was the path psychoanalysis followed in the development of its method, and it seems appropriate here, too.

LESTON L. HAVENS, M.D.
Boston, Mass.

EEG in Schizophrenia

SIR: I was most gratified to read the article by T.M. Itil, M.D., W. Hsu, M.S., B. Saletu, M.D., and S. Mednick, M.D., showing that the EEG may be used to detect high risk for schizophrenia in children ("Computer EEG and Auditory Evoked Potential Investigations in Children at High Risk for Schizophrenia," August 1974 issue).

In 1936, while I was working with Lord Adrian in England, a Russian by the name of Nicholi Propper and I recorded some EEGs on patients at the Cambridgeshire Mental Hospital. We transported on our bicycles the crude EEG machine we had built from the Cambridge University laboratory to the hospital where we recorded the brain waves.

It was my impression at the time that the schizophrenic patients in general had a low level of alpha activity (1). It is rewarding to have this confirmed by the sophisticated research of Dr. Itil and his colleagues.

I also postulated that low alpha activity in schizophrenia indicated poor synchronization of the visual cortical cells (2). It is interesting that other evidence of poor synchronization, such as in eye movements, is now being found in schizophrenia. Perhaps the basic physiopathology of schizophrenia is a lack of coordination of brain functions all the way from the cortical cells to the processes of feeling and thinking (3).

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Capgras Syndrome in Male Siblings

SIR: In his article "The Capgras Syndrome and Its Psychopathology" (August 1974 issue), B. Frank Vogel, M.D., reported that most of the cases of this syndrome in the literature involved women and that the five patients he treated were women.

I have reported (1, 2) on the occurrence of this symptom complex in a 12-year-old boy whom I was able to follow for five years. His preoccupation with doubles, fakes, and aliens continued intermittently throughout the nine months he was in treatment. He responded to oral chlorpromazine (Thorazine) and to repeated interpretation of his symptoms in terms of the changing and conflicting feelings he had for his parents, the accused doubles.

His symptoms were seen in the context of the disordered communication within his family; his parents were also treated. When some interpersonal family tensions had been relieved, the symptoms disappeared in the patient, but they reappeared in his brother.

The younger brother also believed that his parents were benevolent doubles. Because intense rivalry had existed between the two boys, one might expect that this was a competitive identification. However, the younger brother's affect demonstrated that his belief had a deep emotional impact for him. In contrast to Dr. Vogel's patients, these boys were terrified in the presence of the threatening doubles. The younger brother had the illness for about one year, finally responding to treatment similar to what I had used with his brother.

The opportunity to study two instances of Capgras syndrome in the same family caused me to reflect on the role of parental influence in the syndrome. There was a strong history of schizophrenia on both sides of this family, but no other reported instance of belief in doubles. The mother was prone to describe people she knew as "two-faced."

Like Dr. Vogel, I believe that this symptom complex is much more common than one would assume from the number of descriptions in the literature. Children frequently split their parents into good and bad. Melanie Klein described the function of ambivalence states in the following way:

> Ambivalence carried out in a splitting of the imagoes enables the child to gain more trust and belief in its real objects and thus in its internalized ones. At the same time, the paranoid anxieties are directed to the "bad objects." (3, p. 308)

I suspect that this kind of psychological maneuver occurs in many if not all individuals as they grow up through childhood. It is unclear what causes it to persist or to reemerge under stress in particular persons.

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A Transfusion for the Medical Model

SIR: I feel that "From Rationalization to Reason" by Seymour S. Kety, M.D. (September 1974 issue) should also appear in the *Journal of the American Medical Association.*

As I have watched those who are opposed to the medical model assault the medical-psychiatric approach to mental illness, I have wondered where the ethics committee of APA has been. To employ clever semantics to attack one's own profession seems to me untenable. Those of us who have been struggling to upgrade mental hospitals seem to have been deserted by our colleagues.

Dr. Kety's perspective is like a transfusion for mental hospitals, which are anemic in regard to morale, staffing ratios, and training programs. Identity crisis, indeed.

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Schizophrenia and Season of Birth

SIR: The article by Robert A. Woodruff, Jr., M.D., and associates (August 1974 issue) entitled "Psychiatric Illness and Season of Birth" is remarkable in two ways. First, it is remarkable that the authors would publish a study using only 22 schizophrenic patients as subjects. Their purpose was to determine the distribution of schizophrenic births among the months of the year (or signs of the zodiac, as they prefer), and it is impossible to conclude anything when only 22 subjects are distributed among 12 categories. The studies that have shown an excess of schizophrenic births in the winter months have used a total of more than 96,000 schizophrenic patients (1).

Second, the study is remarkable in having used signs of the zodiac rather than months of the year. The authors claim that they did this to make "esoteric and arcane speculation possible." Although this may be amusing, it does not do much to advance research on schizophrenia. There are several good hypotheses to explain why schizophrenics are born more frequently during winter months, including seasonal protein intake (2), a possible association with hemorrhagic disease of the newborn (1), and a possible association with virus infections (3).

The seasonal distribution of schizophrenic births has been clearly established. Our problem now is to develop reasonable theories of etiology that will encompass this and other facts known about the disease. Consigning the seasonal distribution to the realm of astrology with tongue in cheek will not make it go away.

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More on Blame in Family Therapy

SIR: "Mistreatment of Patients' Families by Psychiatrists," by William S. Appleton, M.D. (June 1974 issue) is a long-awaited reevaluation of the family therapy movement and its place in current psychiatric teaching and treatment methods.

It is ironic that family therapists who have attacked the medical model have become entrapped in the same grandiose "I have an explanation for everything" attitude of the tough-minded organicists. The "blaming game" started with labeling mothers as "schizophrenogenic." (Arieti stated that 25 percent of the mothers of schizophrenic persons fit in this category [1], but recently he seems to have moved toward the interaction model, in which mother and child both contribute to the development of the psychopathology.) Next, the blame not only for the perpetuation but for the genesis of that disorder was shifted to the family.

It seems to me that theorizing based on sparse facts or a distorted cognition and perception of the human condition that is schizophrenia has compounded the hardship of patients and their families.

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BOOK REVIEWS

The Psychology of Politics, *by William F. Stone. New York, N.Y., Free Press (Macmillan Publishing Co.), 1974, 278 pp., no price listed (paper).*

Based on personal experience in the field of politics, observations of political life in the United States, his professional background in psychology, and his wide reading in the field, the author attempts to present an integration of selected contributions from social and personality psychology relevant to an understanding of political behavior. He tries to make this book understandable to undergraduates. In view of the chaotic political scene of today and the apparent misapplication of political power, any attempt to help us understand man's motivation for public life and the factors that determine people's choices should be applauded. Stone's attempt is admirable in this respect; it is also largely successful.

In part 1, Introduction to the Study of Political Behavior, the author ranges from an analysis of factors that led to the growth and eventual deterioration of the Oneida community, one of the early communes, to a whirlwind tour of political psychology through the ages. He touches upon the ideas of Plato, Hobbes, Machiavelli, and, of course, Freud, Marx, Lasswell, and Lane. He also notes a modern survey research on the habits of American voters. All these areas are dealt with rather superficially (as the sophisticated psychiatric reader will realize instantly when he peruses the section titled Psychoanalysis and Society), but this seems consistent with the author's goal of educating the bright young mind.

Part 2 focuses on the individual and the way he learns political attitudes. Here we are introduced to Lewin's field theory, factors influencing character development, and the ways in which the individual eventually learns politically colored social reactions.

In part 3, Personality and Motivational Factors, the author discusses self-esteem, power, competence, the Machiavellian personality type, the authoritarian and democratic personality disposition, and the liberal-conservative dimension. The reader will gain insight into the rationale for selecting these particular personality variables for dissection, the technology of their measurement, and their possible use in predicting how specific individuals will behave in the political arena.

Part 4 takes us into the psychology of participation, leadership, ambition, changing political attitudes, and political choice. In the author's discussion of barriers to political participation, we learn that Americans suffer from severe voter apathy and that even in the most heated campaigns participation is disappointingly low here in comparison with other countries. In light of this fact, the author discusses at some length patterns of leadership, the traits of leaders that attract or repel the public, and the elements that made up the charisma of such personalities as Lenin, Gandhi, Franklin D. Roosevelt, and John F. Kennedy. The ways of approaching measurement of these subtle factors will intrigue the research-minded reader.

The author examines the concepts of image and attitude, particularly in relation to the acknowledged difficulty in changing political ideology and voting preferences. If we are to foster public enlightenment and concern for the quality and efficiency of government, these components must receive greater stress in the future.

The volume bears upon great and pervasive public issues. It asks: Can the world powers live in peace, or is war and nuclear annihilation inevitable? How long can the depletion of natural resources and the pollution of the environment continue? Can citizens have faith in their government? How can we induce men and women of great ability and integrity to pursue high office? How does one foster informed, concerned citizen participation so that excellent candidates are recognized and elected?

The theme of the individual in the community is seen as applying to four distinguishable groups: the masses, the elite, the national leaders, and dissident minorities. These groups and their many subgroups are striving for self-interest within a complex society directed by a political system full of foibles, tangles, and tensions. The search for a truly participatory form of democratic society always goes on; although our forefathers left us with a workable and imaginative instrument for self-government, its application to our changing world requires considerable modification. Hopeful developments that appear to increase political awareness of the American electorate are summarized in Stone's quotation from McCloskey (1964):

> "The extraordinary spread of education, rapid social mobility, urbanization, the proliferation of mass media that disseminate public information, the expansion of the middle class, the decline in the size and number of isolated rural groups, the reduction in the proportion of people with submarginal living standards, the incorporation of foreign and minority groups into the culture and their increasing entrance into the professions . . . ." (p. 264)

All of the problems taken up in this book are important. The knowledge available in the field of psychology of politics is meager. The treatment of this knowledge base is necessarily superficial in a volume encompassing so much, but the material is set forth with lucidity and accuracy and the author's style ought to engage the interests of the audience he seeks to enlighten, namely, the intelligent layman. The intelligentsia, on the other hand, may want to look further and deeper once their appetite is whetted by this overview. An excellent reference list of approximately 270 citations will be of assistance in that quest.

MILTON GREENBLATT, M.D.
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Psychiatry and Law, *by Ralph Slovenko, LL.B., Ph.D. Boston, Mass., Little, Brown and Co., 1973, 686 pp., $28.50.*

During the past decade psychiatrists in every sector of our conglomerate discipline have confronted the cutting edge of the law. It is an abrasive edge set in the adversarial vise of the legal process. Most psychiatrists, myself among them, believe that the new onslaught of law has cut away at the psychiatric enterprise without adequate consideration or respect for our difficult mission—the provision of mental health care. In the name of

the Constitution and civil rights, serious impediments to the provision of mental health care have been erected, and the mentally ill, particularly the chronically mentally ill, have been abandoned to their rights.

Many state legislatures have followed the lead of the courts and pushed through sweeping reforms of their mental health laws without providing the funds or the alternative facilities that such changes mandate if treatment is to take place.

Even the so-called right-to-treatment suits have thus far resulted in the reduction of institution census rather than the improvement of quality of care. If psychiatry is to resist this assault, it must do more than grumble and cavil; it must inform itself, understand the relevant legal issues, and then provide direction to the necessary progress of law.

Ralph Slovenko's book on psychiatry and law is a helpful source of the necessary information. Its tone is far more sympathetic to the mission of psychiatry than any of the other texts and law review articles that have appeared recently, e.g., Kittrie's book (1). Dr. Slovenko, a law professor trained in clinical psychiatry, received the Manfred S. Guttmacher Award of the American Psychiatric Association at the 1974 annual meeting for this work.

The book reads easier and better than most texts on law and has a great deal to offer the average psychiatrist. It treats all of the critical areas, e.g., civil commitment, right to treatment, right to refuse treatment, confidentiality and privileged communication, divorce, child custody, testamentary capacity, and psychiatric malpractice. It presents briefly all of the relevant legal doctrines and has a well-chosen set of case illustrations with actual trial testimony, which puts clinical flesh on the legal bones. There is an excellent discussion of how the court deals with evidence, particularly with psychiatric testimony. The adversary structure of law is discussed as it affects psychiatric testimony, and the pros and cons are presented.

The virtue of the book is that it takes the naïve psychiatric reader on a guided tour of a complex field. It is therefore a useful introduction by a man who speaks our language and, by his example, encourages us to speak his. It is a Baedeker, however: it does not present serious original ideas and is not a definitive resource. In fact, judged as a major work, it leaves much to be desired. It is marred by disconcerting, if trivial, errors. It borrows passages from other authors without acknowledgment, and crucial areas of current concern such as sexual psychopath legislation, preventive detention, and the treatment of juveniles are given only cursory treatment.

Nonetheless, for the psychiatrist who wants to be shown through the Louvre on his or her two days in Paris, Slovenko is an admirable if expensive guide. One hopes that the tour will lead many to more prolonged and profound study.

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ALAN A. STONE, M.D.
Cambridge, Mass.

The World of the Urban Working Class, *by Marc Fried. Cambridge, Mass., Harvard University Press, 1973, 404 pp., $15.00.*

This is a valuable reference for students of the relationship between social context and behavior. It concerns the world views and habitual action patterns of working people in Boston's West End, which have much in common with those of people of comparable socioeconomic status in stable industrial societies the world over.

The author's discussion of his data is enriched by a comparative social and historical perspective that enables him to deal comprehensively with such variables as ethnicity, migration, occupation, residence, community structure, and family roles. The impact of reality and of situational factors on values and aspirations as well as on styles of thinking, feeling, and acting inevitably receives much attention. Even these people, who are not of the lowest social class, must come to terms with their social powerlessness, the abrasive quality of daily life, and repeated minor crises and major disasters.

It is in the area of social relations that the findings are of greatest interest to the clinician. Fried identified the "overall imbeddedness in close-knit network relationships . . . the expansion of a kinship orientation to a wider realm of local friends and neighbors" as the feature that "uniquely typifies community life in the working class" (p. 226). This pattern of relating, with its complex ramifications, is ultimately understood as the product of a particular system of social stratification; the most powerful determinant of an individual's role functioning in many different areas is the position he holds in the social class structure.

The data are subject to psychological as well as sociological interpretation throughout the book. Variations in social class realities, for example, determine differences in the consequences of attitudes and personalities as they influence the likelihood of fulfillment or frustration in the effort to realize personal potentials.

The chapter on personality may be the least satisfying to the psychiatric reader. Despite his use of such familiar concepts as anxiety, self-esteem, and ego mastery, Fried makes no reference to the large body of social psychiatric literature. He also includes "extrapolations from pathological models" among the reasons why "personality characteristics of people in different social classes are generally ill understood" (p. 200). But this is quibbling. This organized presentation of a large and unique body of data is a major contribution. These data have great theoretical significance; their full exposition is being continued in further work in progress.

The presentation is enhanced by a final section on the methodology of conducting research with complex psychosocial variables over time in a large population.

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Psychoanalysis and Feminism, *by Juliet Mitchell. New York, N.Y., Pantheon Books (Random House), 1974, 435 pp., $8.95.*

This book attempts to demonstrate the relevance of psychoanalysis to the struggle of women in our contemporary patriarchal society. Unlike feminists who denounce Freud's views on women, Juliet Mitchell believes Freud made an important contribution to the understanding of women's role in our society. She asserts that many feminists do not appreciate Freud's contribution because they construe his observation that many women believe themselves to be inferior, passive, and submissive as a statement of his belief that women are inevitably doomed to an inferior role in society.

In order to clarify her argument against the currently fashionable feminist attacks on Freud, Mitchell reviews many of his basic concepts. Although it indicates considerable familiarity

with and understanding of Freud's writings, her presentation of the psychoanalytic view of femininity is limited by her uncritical acceptance of some of Freud's tenets, her incomplete discussion of others, and her inadequate consideration of those psychoanalysts who followed Freud but emended and extended his observations.

Since Mitchell believes the major issue in the oppression of women is the existence of a patriarchal society, she focuses on Freud's contribution to the understanding of patriarchy, especially in his development of the central role of the father in his formulation of the castration and Oedipus complexes. In her review of Freud, Mitchell portrays the father as the symbol of authority who threatens the boy with castration unless he relinquishes his mother. To avoid this the boy detaches himself from his mother, identifies with his father, and internalizes the father's superego. The already castrated girl accepts her inferior status and submits to the father rather than identifying with him. Thus culture is transmitted by men via the superego, patriarchy is established, and women passively submit to men.

While she recognizes that social factors affect personality development, Mitchell is critical of those who attack Freud for not being sufficiently cognizant of social reality. She believes that this position overlooks the essence of the contribution of psychoanalysis. In her analysis of the work of Reich, Laing, De Beauvoir, and others, she demonstrates their misunderstanding of the concept of the unconscious, their confusion of social and psychic reality, and their tendency to offer utopian and reductionistic solutions.

Unfortunately, Mitchell's solution is as simplistic as some of those she criticizes. She believes patriarchy must be overthrown to end the oppression of women. The arguments on which she bases this conclusion as well as her suggestions for its implementation are difficult to follow. She has been impressed in her reading of Freud by the unconscious determinants of patriarchy. However, she believes that Freud did not go far enough and she turns to Lévi-Strauss to complete her argument. She accepts Lévi-Strauss' controversial thesis that in all societies women are used by men as a medium of exchange to maintain kinship relationships and guarantee exogamy. She views the maintenance of exogamy as a social issue.

Her argument alternates between the psychological and the sociological and her position is not clear. On the one hand, she speaks of the "eternal unconscious"; on the other, she suggests that a different organization of society will change unconscious representations. She advocates major social and economic revolutions that will establish a society in which economic exploitation will disappear and patriarchy will have no place. If patriarchy has no place in society, she argues, its unconscious representations will disappear and there will be no exploitation of women.

This book only partially fulfills its promise to demonstrate the relevance of psychoanalysis to feminism. The author's narrow focus on patriarchy omits many psychoanalytic contributions to the understanding of women, particularly the importance of preoedipal factors in determining gender role. Her wishful solutions neglect many important issues, including one of particular importance to psychoanalysis; i.e., she does not come to grips with the reasons for the dominant role of men in society. Is it the unconscious representation of maleness as a fixed symbol of power or is it attributes such as greater physical strength associated with maleness that determines the assignment of the dominant role in society to men?

We do not yet know the relative strength of unconscious factors and social forces in determining the respective roles and relationships of men and women. Although Juliet Mitchell's book does not adequately deal with these and other matters, it is a useful addition to the literature on feminism because it points out some of the contributions of psychoanalysis to the understanding of women's role in society and raises questions for further exploration.

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Beyond the Best Interests of the Child, *by Joseph Goldstein, Anna Freud, and Albert J. Solnit. New York, N.Y., Free Press (Macmillan Publishing Co.), 1973, 161 pp., $7.95.*

This concise, remarkable monograph stands alone as the definitive exposition of one of the most difficult areas in the interface between psychiatry and law, i.e., what the rights of children are under the law, specifically in placement procedures.

The history of children and the law in America is a sordid tale of neglect and abuse. Colonial America regarded children as important tools of colonization. In terms of dependent children, the law required that they become indentured slaves ("binding out"). The custom grew out of English practice and law, the purpose of which was to reduce vagrancy and provide a form of social control over dependent children. Children reaching "suitable age" were bound out to serve farmers, tradesmen, sea captains, and others. Freeborn boys and girls were placed in involuntary servitude for no other reason than that they were poor. The driving principle behind the disposition of children was the absolute authority of the natural parents to do whatever they pleased with their children.

The reader of this monograph finds, tragically, that the rights of children in placement situations are never considered under current legal practices. The authors have used a simple but very efficient format. The basic parts of the book deal with the problem, suggested guidelines for child placement, including a provision for a model child placement statute, and a final review of their premises.

The authors are careful to define both familiar and new terms for the reader, for example, " 'Child placement' ... encompasses all legislative, judicial, and executive decisions generally or specifically concerned with establishing, administering, or rearranging parent-child relationships" (p. 5). The "wanted child" is one who receives affection and support on a regular basis from at least one adult who values him or her. I feel that this is the most critical definition in the book because it clearly indicates that any caring adult may establish the intimate relationship the law and society prefer to limit to natural parents.

This is the message that runs throughout the book. The only relationship that should be protected by law is one between a child and any adult who brings the intimate, loving relationship to the child that transforms him or her into a wanted child. Yet time and time again we witness placement based on concepts of the rights of biological parents and institutional rights. In vain do we and the authors look for placement based on the rights of the child.

The input of psychoanalytic concepts strengthens the stern legal jargon used throughout the book. At times it reads like a legal handbook, but this is understandable in light of the fact that the authors propose a model child placement statute. They are to be congratulated for moving beyond mere theory and pious pronouncements. In the best legal sense, legal revisions are offered, decisions quoted, and rationale presented.

The authors' reference material is excellent, although I was surprised to find no reference to the book of Sanford N. Katz published in 1971 (1). Katz wrote in a similar style and on a

similar subject. His work relates to studies accomplished at the Yale Law School while he was working under two of the authors of this book.

This is indeed a classic work. One only hopes that its message will bring about significant reform of the placement laws as applied to children.

REFERENCE

1. Katz SN: When Parents Fail: The Law's Response to Family Breakdown. Boston, Beacon Press, 1971

JOHN C. DUFFY, M.D.
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A "Bill of Rights" for Children, *by Henry H. Foster, Jr. Springfield, Ill., Charles C Thomas, 1974, 83 pp., $7.50; $4.95 (paper).*

While introducing a course in forensic child psychiatry to a group of child Fellows, I was dismayed to find that there was no collected body of literature in this area. As a substitute for a text, I used a variety of articles, including a paper I felt would subsequently become a classic entitled "A Bill of Rights for Children" (1). When asked to review this book, I was delighted to discover that Prof. Foster's original article had been expanded to monograph form.

In the preface, Foster describes the origins of this monograph. In 1967 the regular course in family law at New York University was separated into two interrelated courses. The second of these courses, taught by Foster, was titled Children and the Law. Foster faced essentially the same problem I did because of the lack of compiled materials available on the subject. He gathered his material from diverse sources. In surveying the relevant literature in the process of preparing for his course, it became clear to him that the status of children was oppressive and that the usual assumptions were open to question. He further noted that children were rebelling because, like women and slaves, a legal structure theoretically designed to protect their rights was in fact serving to oppress and disenfranchise them. He concluded that children needed a new bill of rights.

The body of Foster's book is an explanation of what he proposes as a bill of rights for children. He makes it clear that although his focus is on the legal rights of children and not their educational, counseling, and larger philosophical problems, he does not believe that these should be ignored. Since he is a lawyer, his perspective focuses on the legal status of youngsters and the administration of justice in those areas which are within his area of expertise.

The format of the book introduces the subject of a children's bill of rights and then devotes a chapter to each of eight carefully defined rights. Foster quotes relevant case law to demonstrate where the law supports or neglects to support each of these rights. As one reads the book, it becomes apparent that these fundamental rights of children are not universally backed by law. Unfortunately, when there is existing law to provide muscle for the enforcement of a right, the administration of the law is often clumsy, unwieldy, cumbersome, and ineffective.

No one is spared from Foster's sad and forthright commentary on the dismal state of children with respect to the law in the United States today. Attorneys, judges, the police, educators, social workers, and psychiatrists are equally criticized for tunnel vision and for consistent treatment of the child as a thing rather than a person with a voice to be used and to be listened to.

Certain reforms are suggested in the body of the book. The primary one is that independant counsel be provided for all children as they come in contact with the law, be it in a child custody case, a delinquency case, or a struggle with a school board. This recommendation is justified in the following way:

> We make this recommendation not because of any all-out commitment to the adversary system but because we are convinced that the adversary system is here to stay and given this system, independent representation is essential if one is to be heard.

While there is obviously much to be said in support of this position, it is unfortunate that Foster does not grapple with the question of the lawyer's dilemma when his client, conceivably a very young child, instructs him to advocate a course clearly contrary to what he perceives to be the child's best interest.

Another suggestion Foster makes is the creation of an office of public guardian. The public guardian "would have the authority of a surrogate parent and ... would be empowered to consent to welfare, medical, and other services for minors who have left home. This guardian's responsibility would be to serve the best interest of a minor and when proper to preserve confidentiality with reference to matters communicated to him." Theoretically, the public guardian would use the psychological skills of counseling, advice, and persuasion rather than ordering. His emphasis would be on social services rather than on legal rights. This guardian would be of value in situations in which minors need help traditionally offered by parents but the parent-child relationships have broken down. Emancipated minors would be free to use these services or reject them. Again, it is unfortunate that it is not made clear whether Foster intends the public guardian to act in a manner consistent with the child's wishes or, like a traditional guardian, in a manner he feels to be in the child's best interest. For instance, he and the child may well differ as to whether it is "proper" to divulge confidential information. Adoption of this proposal appears to have the potential for creating at least as many problems as it could ever hope to solve.

Foster modestly concludes that he probably overlooked many important interests and rights of children. While this may be true, his work does not lack thoroughness. He also notes that he has emphasized the rights of children rather than their duties. This comes from his personal belief that unless children are treated fairly and unless their rights are respected it is idle to speak down to them about duties and responsibilities.

In this short, well-written monograph Foster manages to cover and effectively summarize important areas of the law as they relate to children. He also discusses in some detail the administration of existing law. He possesses the skill that legal writers are either blessed with or acquire—the superb technical ability to footnote, document, and cite the sources from which conclusions are drawn. The book therefore serves not only as a source of one man's thinking about rights for children but as a reference and text in the area of child forensic psychiatry as well.

If pressed to find fault with the book, I wish that space had allowed more discussion of the education in behavioral science, or lack of it, of law students, judges, and legislators. Such education would enable them to avail themselves more comfortably of those insights the behavioral scientists can offer. While dialogue and interaction between social scientists and legal scientists are increasing, there is still much room for improvement. Foster does cite some theory and opinions of leading behavioral scientists supporting his suggested rights, but I wish space had permitted more.

Bearing in mind that a monograph cannot be all things to all people, this criticism is minor and does not detract from the overall usefulness and value of the text to behavioral scientists and legal personnel dealing with children.

REFERENCE

1. Foster HH Jr: A "bill of rights" for children. Bulletin of the American Academy of Psychiatry and Law 1: 199–237, 1972

ELISSA P. BENEDEK, M.D.
Ann Arbor, Mich.

Evaluative Methods in Psychiatric Education, *edited by Hyman L. Muslin, M.D., Robert J. Thurnblad, M.D., Bryce Templeton, M.D., and Christine H. McGuire, M.A. Washington, D.C., American Psychiatric Association, 1974, 220 pp., $10.00.*

This book has a great deal to offer those few psychiatrists who are seriously concerned with conveying what skills they have to younger persons and who are willing to submit to observation, to evaluation, and, perhaps, to change. It is not a book for everybody. It presents information that presumes a considerable knowledge of psychiatric teaching and techniques used in the academic setting. But for those experienced and interested few, a veritable banquet awaits their slow and careful reading.

The book is a compilation of discussions held in 1972 at the Abraham Lincoln School of Medicine in Chicago to update the previous conferences on the subject, at Cornell in 1951 and in Atlanta in 1967. No device seems to have been omitted in this coverage of psychiatric teaching, from simulation of interviews to computer by-play over the cauldron of symptomatology. Even the most experienced professor will gain some insight into the complexities of this, that, or the other technique for teaching, systems to learn what we have taught, and how valid and how reliable our teaching has been.

Like reading the great philosophers, reading each chapter of this book brings a sense of conviction and rightness and sparks enthusiasm to encompass the particular system. When the whole book is read, however, no one system stands out, although none is discounted. Perhaps the reason for this lies in the fact that no matter how esoteric, complex, or mechanized the testing device, psychiatric learning and testing require that a living being participate in a human experience. Only after this experience comes the attempt to codify it for use via infinite numbers, computers, films, questionnaires, or "none of the above."

A good friend of mine, a gynecologist, tells me that the only subject that made much of an impression on him during medical school was psychiatry. He gives as the reason the fact that several times during each week of his psychiatric service, someone talked to him, individually, about what was happening. In no other subject did this occur.

Some skills may simply not yield to quantification. But if one would persist, this book will bring full details and full references to the task. I noted only two slightly negative aspects. One is that only one section concerns itself with any evaluation of the student as he interacts with patients. For much of the text the student is treated in the modern student manner—as an objective peer of the professor who must be taught how to elicit this or that information from patient, movie screen, or computer. Maybe this is how some psychiatrists think, but surely not all. The second point, of no real concern to anyone totally immersed in teaching, is that there is a rapid shift in focus from medical student teaching, psychiatric resident training, and psychoanalytic education. In future volumes I hope these strands could be kept clear because the goals of these three groups are really not the same.

RAYMOND HEADLEE, M.D.
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The Prediction of Suicide, *edited by Aaron T. Beck, M.D., Harvey L. P. Resnik, M.D., and Dan J. Lettieri, Ph.D. Bowie, Md., Charles Press, 1974, 249 pp., no price listed.*

This book reflects the increased level of sophistication that has developed over the past decade regarding suicide, our ability to predict it, and, most especially, our ability to prevent it. Formerly, we felt that one could prevent suicide simply by identifying high-risk individuals and publicizing information regarding how persons in trouble could get help. (Of course, we had the same idea about the prevention of venereal disease, drug addiction, and alcoholism.) While the authors of this compendium have not yet looked critically at the possibility that preventive efforts regarding all of the self-destructive behaviors may in fact paradoxically make them increase, they quite adequately bring us up-to-date with the current state of the field.

The book is the result of a conference held in October 1971, under the sponsorship of the Center for Studies of Suicide Prevention of the National Institute of Mental Health. The purpose of the conference was to study the state of the field of suicide prevention and to promote collaborative efforts among researchers. The book is divided into five sections: Historical and Philosophical Perspectives on Classification, The Conceptual Area of Inquiry, Basic Research Issues in Suicide Prevention, Clinical Issues in Suicide Prediction, and Suicide Prediction Scales and Applications.

The first section consists of a single chapter by Joseph Zubin concerning observations on nosological issues in the classification of suicidal behavior. This scholarly chapter sets an admirable tone for the remainder of the book. Zubin describes several scientific models for thinking about suicidal behavior, e.g., the ecological model, the developmental model, the learning theory model, the genetic model, an internal environmental model, and a neurophysiological model. He follows this with a discussion of methodological problems.

The second section is introduced by Alex Pokorny's "A Scheme for Classifying Suicidal Behaviors." He provides a straightforward and understandable consensus for the classification of suicide. Aaron Beck, Dean Schuyler, and Ira Herman discuss developmental scales of suicidal intent in chapter 3.

The third part of the book is introduced by James Diggory's discussion of problems in the use of demographic data and multiple regression methods of analysis. David Lester then describes the use of a variety of standard psychological tests as well as tests specially devised for the prediction of suicide. Jerome A. Motto reports on variables involved in predicting suicide in a large study of inpatients in San Francisco and R.C.B. Aitken describes a method for the measurement of mood by analog.

In the fourth section George Murphy demonstrates his usual careful, critical approach in his discussion of the clinical identification of suicidal risk and Dan Lettieri and Alexis Nehemkis discuss a scale for certifying the mode of death. The team of Robert Litman, Norman Farberow, Carl Wold, and Timothy Brown of Los Angeles report additional efforts to quantify the concept of suicidal lethality. They favor a two-stage screening process.

Dan Lettieri presents a number of suicidal death prediction scales and Avery Weisman and J.W. Worden follow this with a "risk-rescue rating" for the assessment of lethality of suicide attempts in the fifth section. A brief chapter by Robert Sterling-Smith listing the dose of many commonly available drugs required to kill most people follows; one hopes that this chapter is not reproduced for wide dissemination to "do-it-yourselfers." The book concludes with a chapter by William Zung that presents another rating scale for suicide prevention that may be more appealing to the interests of clinical psychiatrists than the ones given earlier in the book.

If one had to recommend a single recent book on suicide, this one would have priority because of the diverse and extensive experience of the participants and because it has excellent references.

PAUL H. BLACHLY, M.D.
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The Technique of Psychoanalytic Psychotherapy, vol. 2, *by Robert J. Langs, M.D. New York, N.Y., Jason Aronson, 1974, 527 pp., $15.00.*

Volume 2 of Dr. Langs's *Technique of Psychoanalytic Psychotherapy* continues in encyclopedic detail his presentation of this particular mode of psychotherapy. This volume includes three major sections—Responses to Interventions, The Patient-Therapist Relationship, and The Phases of Psychotherapy. Of the three sections, the one on the patient-therapist relationship is the longest by far, indicating where the author places his primary emphasis. In the sections on responses to interventions and the patient-therapist relationship, Langs considers almost every conceivable situation that may arise to prevent progress or to create impasses in treatment. His instructions for relief of these barriers to progress are clear and straightforward.

The volume is replete with clinical vignettes illustrating every facet of progression, regression, or impasse that may occur. These are drawn mostly from the author's work as supervisor of psychiatric residents; a substantial number are from his own practice. Here, too, Langs does not spare the printed page. In contrast to the usual practice, his vignettes are of sufficient detail to give the reader a genuine sense of the nature of the case and the problem that has arisen.

Dr. Langs's view of psychoanalytic psychotherapy—his close adherence to classical psychoanalytic theory—provides a firm conceptual model for the conduct of therapy. It may seem too rigid to some in its unswerving psychoanalytic stance in respect to investigation, understanding, and resolution. However, one can make a very good argument for the fact that there is more rather than less need now for thoughtful, conceptually sound treatment models.

It seems to me that far too much influence continues to be placed on therapists to do what comes naturally. Implicit in this idea is that there are no genuine models or sound theoretical constructs to follow, except for whatever inner dictates the therapist feels ready to pursue, and that careful, intensive training in the science and art of psychotherapy is unnecessary. Langs demonstrates very well that the psychoanalytic psychotherapist has ample opportunity to be flexible in his work, provided the degree and kind of flexibility chosen is grounded in theory and in observations borne out in practice. Langs carefully documents the misalliances, therapeutic errors, and therapeutic gains that follow directly on the degree of understanding of human behavior that the therapist brings to his work. He highlights in theory and in practice the exquisite nature, subtleties, and nuances of the psychotherapeutic relationship.

It is most impressive to note Langs's dedicated position in promoting independence and autonomy in patients with minimal interference by the therapist. This is in the finest tradition of psychiatry as a humane science. It also accounts for the extensive attention Langs pays to the patient-therapist relationship and all the problems of countertransference that arise so readily and interfere so pointedly by preventing the patient from finding his own way to the inner changes that would allow greater self-fulfillment. Langs makes clear the constant need for self-examination by the therapist in the best interests of the patient. One can only agree with him that there is no substitute for personal analysis to bring light to those parts of the therapist's emotional life which he cannot illuminate and find by himself.

There is not very much in the literature about the opening, middle, and closing phases of psychotherapy. The middle phase, particularly, is so often vague and ambiguous in its boundaries that Langs does a service by elaborating on it. He discusses the middle phase in terms of further delineation of those central issues which are directly related to the unconscious fantasies that are the source of the patient's disability.

The section on the closing phase is also excellent and worthy of special attention because it is here that the least effective work tends to be done. Separations and terminations are the human plague to which no man is immune, patient and therapist alike. Terminations reverberate as much in the therapist as in his patient, and the demand for sensitive understanding of oneself is as important as the understanding of the patient and as the skill that must be brought to bear to bring treatment to a successful close. In this connection, it is interesting to note that so many of the clinical vignettes center around the errors committed at the time of separation and termination.

The only criticism one may make is that there is considerable repetition in the course of the volume. Even this criticism is moderated by the pedagogic value of repetition as useful in learning. This book is a superb reference source, the kind a therapist should have on his shelf for ready reference when confronted with a difficult or puzzling situation in the course of his work.

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The Competent Infant: Research and Commentary, *edited by L. Joseph Stone, Henrietta T. Smith, and Lois B. Murphy. New York, N.Y., Basic Books, 1974, 1,281 pp., $30.00.*

This volume is a must for all students and professional workers concerned with the development of the human infant. The editors, themselves eminent scholars in the field, have selected and edited over 202 studies. They have organized these studies into sections covering individuality in development, prenatal and perinatal development, the capabilities of the newborn, development during the first year, deprivation and enrichment, and the infant as a social being. The various sections have introductory commentaries that are scholarly tours de force. The commentaries point up the significance of the articles chosen, put them in perspective with other work and trends in the field, and review succinctly, thoughtfully, and lucidly the state of the science in each area. Each commentary includes an extensive bibliography covering the relevant literature. There is an excellent index.

In their introduction the editors comment on the previously prevalent professional judgment, which still persists, that the young human infant is an undeveloped, undifferentiated, and primitively responsive organism. The explosion of research in the past 20 years has produced, in the editors' words, a "vast new landscape of knowledge of infancy." This new landscape belies the earlier contention that the human infant is undifferentiated and primitively responsive. Rather, it shows that "from his earliest days, every infant is an active, perceiving, learning, and information-organizing individual," hence the editors' title, *The Competent Infant.*

Even with such a scholarly and authoritative compendium a reviewer is bound by his or her own viewpoint and experience to find some omissions or underemphases. The extensive and pertinent animal studies contain no selections by Schneirla and no mention of his leading coworkers, although this group has made highly significant contributions to the study of behavioral development. The contributions of two leading research child psychiatrists, Chess and Rutter, are given only very brief mention, and Fish is omitted completely. Two articles by Spitz on hospitalism are selected, but none by any of his critics.

However, these are minor criticisms of a work that should become not only a standard reference source but an important original and stimulating contribution to the exploration of this exciting new landscape of knowledge of infant development.

ALEXANDER THOMAS, M.D.
New York, N.Y.

Individual Differences in Children, *edited by Jack C. Westman, M.D. New York, N.Y., John Wiley & Sons, 1973, 335 pp., $15.95.*

This excellent collection of readings expresses Freud's long-neglected assertion that from the beginning, each individual ego is endowed with its own peculiar dispositions and tendencies. This book stresses the fact that constitution is a sum total of structural, functional, and psychological characteristics. The fact that it is compiled of many articles by many authors does not deter from its importance. The most distinguished and interesting workers in the field of child development have been brought together in this volume. The common thread is well maintained and emerges clearly—namely, individual differences in children are important.

The monograph consists of five well-structured and complementary parts. Each is forworded by an excellent summary by Jack Westman that pulls together the essence of the chapters. The first part deals with foundations and structural determinants of early infant behavior as well as with sex differences. The second addresses itself to developmental perspectives and moves from early expression, to the termperament of normal infants, to cognitive structure in latency and adolescence. The third part handles situational perspectives, environmental conditions, and the impact of parent-child relations. It also considers such interesting aspects as birth order and its meaning. The fourth part deals with biological as well as methodological research models. It includes intensive observation of the preschool child and primate personality research. The fifth section deals with the clinical application of measuring infant temperament in pediatric practice. Finally, Westman's summary pulls together all of the material discussed in the book and highlights its significance.

Several articles in this excellent book indicate that we are no longer discussing the prematurely born and maternally deprived child in general terms; we are able to look beyond that frame of reference and see how individual maturational sequences determine future development. Transactions between child and mother are not best observed in an artificially designed testing setting. (Observation is especially useful at the very early stages of development, before the complexity of the cognitive structure of the person emerges.) In addition to participant observation and direct study of early life, we are able to link behavioral observations with behavioral determinants. Moreover, it is now possible to make statements about observed behavior in a developmental framework and connect both intrapsychic and manifest behavioral phenomena over time.

Each part of this book is preceded by a well-selected quote; Charles Darwin's seems to express the spirit of the whole work:

> No two individuals of the same race are quite alike. We may compare millions of faces, and each will be distinct.

I strongly recommend this monograph to all professionals who are ready to broaden their scope and allow new ideas to make their proper impact.

LEON TEC, M.D.
Norwalk, Conn.

Mental Illness and the Economy, *by M. Harvey Brenner. Cambridge, Mass., Harvard University Press, 1973, 281 pp., $15.00.*

Dr. Brenner has produced systematic data on the relationship between mental illness and economic variables from which he concludes that a major paradigmatic shift in perspective may be essential. He suggests that the problems of persons who have been mentally hospitalized as a result of downward economic mobility are usually the result not of their own incompetence but of large-scale economic instability in the society—especially the instability manifested in short-term downturns.

Is Brenner acceding to an ecological fallacy or is he attempting to alert the psychiatric profession to a more sensitive stance toward environmental variables? He states,

> These findings raise questions about the utility of therapies that do not take into account disturbances in the patients' social environment which may have made treatment necessary. (p. xi)

Unfortunately, Brenner's description of the statistical procedures employed may be too brief to assess the validity of the methodology. A technical appendix in a later edition would complement the lucid outline of his approach found in the introduction and in the supportive bibliographical citations throughout this text.

Several of the findings are disturbing. Married persons show the most reliable inverse relationship between admissions to mental hospitals and economic change, whereas groups of single persons display only a moderately reliable relation. Farmers, laborers, and salesmen appear to be most vulnerable. Economic downturns occurring during periods of large-scale prosperity produce enormous increases in mental health treatment. Further research is required to determine whether or not the loss of employment, income, or both is correlated with an increase in the incidence of mental illness.

This study offers many leads to specific items of research on the relationship between the economy and mental illness. Policy makers concerned with the economy or mental health desire

such research and need critiques of Brenner's findings because they may be continually faced with the decline of economic institutions and the growth of social and health industries designed to deal with a variety of problems related to the decline.

The psychiatric profession cannot afford to ignore Brenner's readable and scholarly study. It must debate his contention that American clinicians involved in psychiatric care operate under a set of values and beliefs that are probably antithetical to the perspective of this study. Is the transition from Brenner's finding about the relationship of the economy and mental illness to his judgment about the profession justified? Is Brenner's macro viewpoint irreconcilable with the micro approach of clinicians? Brenner's analysis is not a definitive work but a promising beginning; the clinicians have yet to be heard.

HENRY A. FOLEY, PH.D.
Rockville, Md.

The Diphenylbutylpiperidines. First North American Symposium, 1972, *edited by André Villeneuve, M.D., and Jean-Marc Bordeleau, M.D. Québec, Canada, Les Presses de l'Université Laval, 1973, 134 pp., no price listed (paper).*

Interest in the long-acting oral and injectable neuroleptics has mushroomed worldwide in recent years. This interest has been sparked by the advent of a variety of these agents—seven injectables and three orals (pimozide, penfluridol, and pipothiazine)—and by the testimony of investigators about their efficacy and safety as well as the impact they may have on the economics of mental health care.

This book consists of the papers presented in Montreal in 1972 at the first North American symposium on the diphenylbutylpiperidines, a new series of neuroleptics synthesized by Paul Janssen. Dr. Janssen is the "father" of the butyrophenones and many other drugs active in the central nervous system. To date, only three of the diphenylbutylpiperidines have been tested clinically: the oral pimozide, which has a duration of action of over 24 hours and hence is administered only once daily; penfluridol, which has the longest duration of action of any known oral neuroleptic and is usually administered only once every 5 to 10 days; and the long-acting injectable fluspirilene, which has an average duration of action of 7 days and is usually administered once a week. Pimozide is marketed outside the United States under the trade name Orap. The commercial introduction of all three substances worldwide is probably only a matter of time.

The opening chapter makes up almost one-third of this monograph. It is an excellent review of the chemistry and pharmacology of long-acting nueroleptics by Dr. Janssen. The remainder of the book consists of relatively short chapters reporting on the results of open and double-blind controlled studies of pimozide and fluspirilene by different Canadian clinical investigators. One of these reports has been printed previously under a different title (1). Each of these reports verifies again the efficacy and safety of pimozide and fluspirilene in the maintenance treatment of chronic psychotic patients, especially schizophrenic patients.

Although there is enough information on pimozide and fluspirilene in this short book that its purpose is fulfilled, it must be stated that anyone who wants more than a modicum of knowledge about these compounds must turn to other sources of data. In my judgment, psychiatrists should become familiar with the long-acting neuroleptics; there is no doubt that they will play an ever-increasing role in drug therapy for psychoses.

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1. Saint-Laurent J, Carle R, Domingue D: Fluspirilene in the treatment of chronic schizophrenic outpatients. Curr Ther Res 14:599–608, 1972

FRANK J. AYD, JR., M.D.
Baltimore, Md.

Family Psychiatry for Child Psychiatrists, *by John G. Howells. Ipswich, England, Institute of Family Psychiatry, 1972, 50 pp., 50 pence (paper).*

This excellent little monograph is a concise description of the organization and operation of child psychiatric services in Great Britain.

The title reflects the author's conviction that the child is best treated by an approach that takes the family as the patient, along with the corollary that child or family psychiatric services are best located in hospital settings, close to parallel psychiatric services for adults. The presentation is authoritative, straightforward, without much discussion of alternative points of view, but balanced and sensible. (There are many references to the way things are done at Ipswich.)

American readers will find much of interest here. Psychiatric services for children in Great Britain have been coping with the task of serving an entire population under the National Health Service program for 25 years. The experience has led to some conclusions about coverage, types of services, and the way these services should relate to other services for children such as schools, medical services, and family practitioners.

RICHARD S. WARD, M.D.
Atlanta, Ga.

Support, Innovation, and Autonomy: Tavistock Clinic Golden Jubilee Papers, *edited by Robert Gosling. New York, N.Y., Barnes & Noble Books (Harper & Row, distributor), 1974, 289 pp., $16.50.*

Many of the papers collected in this book were read on the occasion of the golden jubilee of the Tavistock Clinic. They are all skillfully interrelated and deal with the development of autonomy in the individual and the antecedent support and innovative steps essential to the development of a genuine personal autonomy.

Dr. Gosling has given us a magnificent example of competent editing. Unlike the usual collections of papers loosely held together in a volume of this sort, his frequent editorial comments and careful selection of topics and styles provide the continuity usually seen only in books by a single author. The authors of the papers, too numerous to mention by name, are outstanding authorities who demonstrate considerable ability in presenting their topics succinctly and with integration.

An introduction by the editor describes his concepts of support and innovation as they are operative in all phases of society from the smallest unit, the family, to such highly complex units as industry, schools, and hospitals.

The early roots of autonomy in childhood are considered in papers on self-reliance and substitute mothering during family crises. The impairment of autonomy in a child whose mother is physically present but emotionally unavailable is well documented.

Two dramatic papers, one on dependence and independence in an institution for incurable patients and the other on attach-

ment and autonomy at the end of life, provide insight into the role of autonomy in people who are severely challenged by immutable personal crises.

Autonomy is also impaired in psychological dislocation, as in the case of a conflicted marriage relationship. Psychotherapeutic intervention in such a marriage is presented by case study material. Therapeutic factors in analytically oriented brief psychotherapy are also considered.

The final section of the book discusses the practical exercise of autonomy in various aspects of employment (i.e., absenteeism, casualties, etc.), in personality factors involved in joining a new group, in family enabling processes in dual-career families, and in the roles of silence in intrafamilial hostility.

There is much to be gained from reading this book. In no other volume have I ever seen the concept of the development of autonomy, its antecedents, its modifications within the family and by therapy, and its role in mature life so well presented. It is recommended reading for psychiatrists and other sophisticated students of mental health.

LUDWIG M. FRANK, M.D.
West Hartford, Conn.

The Psychoanalytic Study of the Child, vol. 28, *edited by Ruth S. Eissler, M.D., Anna Freud, LL.D., D.Sc., Marianne Kris, M.D., and Albert J. Solnit, M.D. New Haven, Conn., Yale University Press, 1973, 511 pp., $15.00.*

Since it began publication in 1945, this annual has been a keystone in the psychoanalytic literature. Its policy is and has been to present research findings from the psychoanalytic treatment and observation of children as well as theoretical papers pertaining especially to the genetic point of view, which pertains to the origins and development of psychological phenomena in the individual (1). Psychoanalytic metapsychology consists of the set of essential assumptions on which psychoanalytic theory is based. It includes five points of view: the dynamic, the economic, the structural, the genetic, and the adaptive.

This issue is in its usual format, with papers in four categories: Aspects of Normal and Pathological Development, Clinical Contributions, Contributions to Psychoanalytic Theory, and Applications of Psychoanalysis.

The first section has articles based on direct study of children through treatment and/or observation. There is an exploration of the preoedipal infant-father relationship and a reexamination of the impact of the primal scene on child development.

The findings of a psychodynamic study of "gifted underachievers," if confirmed, will have important implications for early childhood education, particularly education that occurs within the family. An article on childhood psychosis is based on the treatment of a four-year-old whose struggle for separation and individuation was reflected in the vicissitudes of her bladder and bowel functioning. Another, on the infantile fetish, scrutinizes the classical psychoanalytic theory of fetishism through observation of 35 infants in a research nursery.

The clinical contributions are cogent and well written, beginning with a report of the analysis of the son of a refugee and how that reality colored the form of his neurosis. Another paper examines the similarities and differences between separation-individuation in early childhood and the adolescent's struggle for genital primacy and object removal. Others report on the effect of rape on children, the efficacy of preventive analysis following trauma, the incredible technical difficulties of analyzing a disturbed deaf-mute child, and the place of "preparatory educational help" for children who are initially unanalyzable.

The material in the theory section, aside from being esoteric to the interests of nonanalysts, is composed of four articles that are uneven in the extent to which they advance theory building in psychoanalysis. There is a somewhat abstruse essay on interpretation from the point of view of semantics that contains the often-repeated caution that in analysis we interpret in the language of the present affects and experiences of the past that had very different verbal representation or none at all.

A paper on the concept of aggression attempts to solve the very old problem of explaining aggression without resorting to the instinct concept. The approach is to assume that both aggression and libido derive from an inborn "automatic flight mechanism" whose direction is determined by the environment. An article on acting out as a character trait is not really theoretical but actually a rather good paper on technique. One on attachment to painful feelings and the negative therapeutic reaction is interesting as a clinical report. Its theoretical ideas are not convincingly different from those offered for masochism in the past, although the author attempts to put them on a broader base.

The chapter on applications of analysis has a report on psychoanalytic research into the intellectual functioning of black children reared in a ghetto. The findings are modest and are in line with prevailing expectations. There is a study of a child's game called "jinx" and a delightful view into the lives and creativity of A.E. Housman and René Magritte in a paper titled "The Image of the Lost Parent."

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WILLIAM R. FLYNN, M.D.
Encino, Calif.

Eysenck on Extraversion, *by H.J. Eysenck. New York, N.Y., Halsted Press (John Wiley & Sons), 1973, 174 pp., $4.95 (paper).*

In the historical introduction of this book Eysenck notes that he resurrected the concept of extraversion-introversion and in so doing created somewhat of a stir among psychologists interested in personality. The concept had been popularized by C.G. Jung, although it did not originate with him. However, like many other concepts unsupported by empirical evidence, it fell into general disrepute in academic circles.

Eysenck's use of the terms extraversion and introversion is not identical to that of Jung. Rather, it represents an attempt to link together the neural and cognitive control theories of functioning. Klein and associates (1) presented an excellent evaluation of Eysenck's analysis of extraversion-introversion in 1967.

Eysenck's book consists of research articles previously published elsewhere. It is a book of readings, a smaller version of a three-volume work published in 1971 (2). It is arranged into three parts covering the nature of extraversion, extraversion and social behavior, and the experimental study of extraversion. Each paper is a scientific study of a particular dimension of extraversion. The reader will find as he reads each chapter that he gets not only a greater appreciation of the concept of extraversion but also a greater insight into the man, scientist, and scholar Hans Jurgen Eysenck.

Extraversion as Eysenck envisions it has two aspects, the phenotypical and the genotypical. His concern is not simply to classify behavior in terms of everyday activity but to understand it in terms of inherited characteristics, particularly the inherited disposition of the central nervous system. The reader is carefully brought through general principles and methods of personality description, classification, and diagnosis. Gradually he is introduced to an understanding of extraversion in terms of a concept and a factor. The rigid scientific method is ever present throughout the book. Eysenck does not let the reader forget that he is a scientist as he develops hypotheses and subjects them to experimental scrutiny with the assistance of statistical techniques, the favored of which is factor analysis.

Undoubtedly, certain chapters will appeal more to some than to others. However, the heuristic quality of this book is irresistible, subtly encouraging the reader to test the hypotheses generated. For this alone the book is well worth having in one's library.

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DOMINIC R. MARINO, PH.D.
Somers, Conn.

Practical Aspects of Mental Health Consultation, *edited by Jack Zusman, M.D., and David L. Davidson, M.D. Springfield, Ill., Charles C Thomas, 1972, 152 pp., $6.75.*

The product of a conference on community psychiatry held at the State University of New York, Buffalo, in 1970, this volume presents most of the papers given at the seminar concerned with the subject of mental health consultation.

The social importance of this field is stressed. The writers focus on the potentially broad impact of mental health consultation on issues of mental health prophylaxis and on community attitudes toward the theory and practice of mental health care as well as the enormous challenge and complexity of developing an effective process of consultation. The great need for further information and experience and the ultimate development of a well-defined and systematic body of knowledge is acknowledged; the papers compiled in this book are presented as another step in this direction.

The book is subdivided into sections dealing with particular aspects of mental health consultation. These include, among others, the theory of consultation, the practical aspects of the consultation process, the training of consultants, and discussion of the distinctions among consultation, supervision, and psychotherapy.

The interest and value of the volume are greatly enhanced by the multidisciplinary background of its contributors. The fields of psychiatry, psychology, social work, education, and nursing are represented. The purpose and process of consultation are discussed in a stimulating manner from a number of different perspectives—from the point of view of the consultee as well as the consultant. As the title suggests, much of the material is highly practical and would be valuable to individuals involved in the practice of mental health consultation.

DAVID W. WYCKOFF, M.D.
Newtown, Conn.

Assessment of Sexual Function: A Guide to Interviewing, *by the Group for the Advancement of Psychiatry Committee on Medical Education. New York, N.Y., Jason Aronson, 1974, 92 pp., $7.50.*

This GAP report is designed as a "manual for the practicing physician, the medical student, and others in the health field." Emphasizing an open-ended, semistructured interviewing technique as the sine qua non of eliciting information from the patient, the guide first attends to the interviewer, his or her attitudes, and the setting of the interview.

Neither the initial interview nor the specific questions identified in Appendix A ("Topics Covered in a Sexual History") and Appendix B ("Sexual Performance Evaluation") is intended to communicate that the taking of a sexual history should be a specific form of interrogation or relationship separate from the rest of the interview. Rather, the skillful and experienced interviewer will incorporate and/or adapt many of the suggestions offered to his or her unique interview style.

In subsequent chapters, the guide is addressed to specific sexual problems of the married couple; the sexual functioning of children, adolescents, "other" single persons, and older people; and covert sexual problems presenting symptoms relating to other organ systems and to depression.

Manuals of the how-to-do-it sort invariably engender mixed reactions in the reader. They tend to appear superficial, naïve, spotty in coverage of a broad subject, and dogmatic despite apologies and protests to the contrary. On the other hand, their strength lies in directness and succinctness.

A specific criticism of this book is that despite the fact that it was prepared by psychiatrists, there is little that is "psychological" in its approach. It is a bit too mechanistic. Patients often do not present sexual problems as such; "straightforward" history taking may increase their resistance. Sexual problems may often remain unelicited until the third or fourth interview and occasionally not until months after the development of a patient-physician relationship.

Paradoxically, there are some valuable pointers in this book that the sophisticated interviewer may add to his or her interview, while the unsophisticate may use it too directly and mechanistically. In summary, whereas it is a useful guide for the physician, it is not sensitive enough psychologically to have warranted preparation by psychiatrists. A bibliography directing the reader to more extensive primary sources rather than to other manuals would be a valuable addition.

CHASE PATTERSON KIMBALL, M.D.
Chicago, Ill.

A Psychoanalytic Study of the Psychoses, *by Thomas Freeman, M.D. New York, N.Y., International Universities Press, 1973, 328 pp., $10.00.*

There are two psychoanalytic models for psychosis, for schizophrenia in particular, the deficit model and the defense model. The first corresponds to what London (1) called Freud's specific theory. According to this theory psychosis is clearly separated from neurosis. The defense model corresponds to the unitary theory, which postulates that there are intrapsychic conflicts and motives common to neurosis and psychosis. Both models are consistent with etiological theories of constitutional weakness, genetic anomaly, and theories of schizophrenogenic mothering or severe trauma.

In the deficit model, there is a deficiency state that consists of

a failure to maintain unconscious mental representations. Freud originally described this as a shift in libidinal investment away from object representations to the self 15 years before he postulated the structural theory of an organized ego.

It is unfortunate that this concept, the disruption of the mental organization of memory traces that represent internalization and integration of experiences, has until recently been couched in terms of psychic energy and outdated formulations of narcissism. The nonautonomous part of the ego is built from internalized bits and pieces of experiences, including drives, defenses, anxiety and other affects, and, especially, the coping mechanisms and regulatory functions of the mother. The psychological weakness in the capacity to organize and maintain internalized self and object representations under stress is the ego deficit.

The defense model is based on the theories of conflict, signal anxiety, defense, and regression. Due to innate or experiential factors, developmental disturbances in the psychotic are earlier and more severe than in the neurotic. Consequently, greater conflict over aggression occurs. The defensive process is characterized by greater regression. In the heirarchy of defenses against anxiety and impulse, the psychotic employs such primitive measures as denial, disavowal, and ego splitting. The ego is not able to maintain secondary autonomies against the intense conflict and regression and undergoes regressive alteration in the service of defense.

In this book Dr. Freeman applies the profile schema developed at Anna Freud's child therapy clinic at Hampstead to the fuller understanding of psychotic patients. There is a useful intermingling of theoretical concepts with a wide variety of illustrative case reports. The author's position is an amalgam of the deficit and the defense theoretical models. Unfortunately, the integration is incomplete because Freeman couches the deficit concept in the older framework of cathectic shifts from object to self. He ignores such modern concepts as Jacobson's self-object representations and Mahler's separation-individuation phases.

While profile schemas enable the investigator to compare one patient to another or to evaluate progress in a given patient, I question whether an adult profile provides more than an elaborate systematic mental status. The Hampstead profile was developed specifically for children because it was found that pathology in childhood was best assessed in terms of factors interfering with normal forward development rather than in terms of severity of symptoms. For this reason, profile schemas have limited application to adult pathology.

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ROBERT D. GILLMAN, M.D.
Washington, D.C.

The Diagnosis and Management of Depression, *by Aaron T. Beck, M.D. Philadelphia, Pa., University of Pennsylvania Press, 1973, 147 pp., $8.50.*

De gustibus non est disputandum. Some readers prefer encyclopedic tomes that cite every paper in the literature. Other tastes run to the thin monograph that covers a topic concisely. Aaron Beck can do both. This book is an abridged and updated version of his comprehensive volume *Depression: Causes and Treatment* (1).

In a well-organized, lucid, and useful manner, Beck has given us a book that will be helpful to medical students, psychiatric residents, and mental health practitioners. He highlights the four major issues on the topic of depression: 1) whether depression is an exaggeration of a normal mood or is qualitatively different; 2) whether depression is a disease or a symptom; 3) whether depression is a reaction or a disease; and 4) whether depression is caused by psychological stress or biological derangement. He defines the basic symptoms as specific mood changes, negative self-concept, regressive and self-punitive wishes, vegetative changes, and change in activity level.

In chapter 2 Beck reviews the symptoms of depression, offering not only a review of the existing literature but the results of his own study of over 1,000 patients. The third chapter is about course and prognosis, reviewing whether the illness is episodic or cyclical and what are the prospects for recovery, the duration of attacks, the likelihood of recurrence, and the risk of suicide. The fourth chapter concerns classification and various dualisms about depression, e.g., is depression endogenous or exogenous, autonomic or reactive, agitated or retarded, psychotic or neurotic?

The neurotic-psychotic dualism is the subject of the fifth chapter. Beck feels that no specific signs or symptoms other than delusions are able to distinguish the two. The more severe the depression, the more likely it is to be called psychotic; the differences are quantitative. The chapter on pharmacotherapy reviews 232 studies. It is especially helpful on the subjects of management of side effects and the differences between the effects of antidepressants and electroconvulsive therapy (ECT). The seventh chapter focuses specifically on ECT and reviews the evidence that many patients who do not respond to medication will improve with ECT. The chapter on psychotherapy gives the schema of Beck's own approach, which he calls "cognitive psychotherapy."

There is an excellent general bibliography. The chapter on pharmacotherapy, unlike the other chapters, includes a complete literature review. Dr. Beck explains that this material needs to be updated; for that reason the recent literature on antidepressants is covered thoroughly. Chapters are arranged with logical subheadings, which makes it easy for the clinician to find answers to specific questions. While it is difficult to fault this book, one might criticize the fact that there is little about hospital management of depressed patients. There is also no comment on the family of the depressed patient or on working with the patient in group or family psychotherapy. The book also suffers from the lack of a general index.

In spite of these minor criticisms, the book is a very useful addition to the literature and will be of help to the clinician who treats depressed patients.

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DONALD G. LANGSLEY, M.D.
Sacramento, Calif.

Dying and Dignity: The Meaning and Control of a Personal Death, *by Melvin J. Krant, M.D. Springfield, Ill., Charles C Thomas, 1974, 154 pp. $7.95; $5.95 (paper).*

This small volume on dying, which represents the author's personal viewpoint, is intended for the general public. As such it may prove a useful catalyst of public debate. Dr. Krant notes

that the circumstances surrounding death have been changing. Most people die in their old age and in hospitals, where the precise timing and manner of their dying are under the ever increasing control of physicians. Krant feels that because we see less of death we are less prepared for it and that because people die in institutional settings they suffer their isolating and dehumanizing influences. Krant also believes that modern technology is abused by physicians who sustain lives long after they have lost their human qualities. He views the cost of this in human resources and dignity as enormous.

Dr. Krant urges more open communication with dying patients; he feels that greater responsibility for decision making should be placed in the hands of these patients and their families. This calls for a less rigid and authoritarian approach on the part of many physicians. He advocates more personal and flexible institutional care that would involve greater teamwork and continuity on the part of professionals. In his view, a patient's request for termination of his life should be given serious consideration. While he favors active euthanasia, his words are appropriately cautious.

Although somewhat repetitious, this book is simply and clearly written. Some parts lack the freshness provided in other sections by clinical illustrations. While the author has furnished no final answers—nor could he—he has increased our awareness and furthered our debate of these important issues. The book offers an overview of the subject that might prove useful to students enrolled in courses on death and dying.

RUSSELL NOYES, M.D.
Iowa City, Iowa

A Second Look at Life. Transplantation and Dialysis Patients: Their Own Stories, *edited by Felix T. Rapaport, M.D. New York, N.Y., Grune & Stratton, 1973, 91 pp., $5.95.*

This book is the result of a symposium held in September 1972 attended by kidney transplant and dialysis patients from all over the United States. Some of the presentations given at this symposium were published as a journal issue of *Transplantation Proceedings* in June 1973. These have now been republished in the form of this book.

The major purpose of the book as indicated by its editor is to bring renewed hope, faith, and confidence to patients with kidney disease. Only as a secondary aim is it hoped that the book will be useful to professionals in providing insight into the social, psychological, and ethical problems of this particular patient group. The book has three basic parts: 1) a series of three- to four-page testimonials from 15 patients, 2) another series of short vignettes from 6 transplant donors, and 3) seven articles by professionals on the ethics, costs, and psychology of transplantation.

In terms of its primary goal, which is one of public relations, the book vividly illustrates to potential patients, federal funders, and referring physicians that kidney transplantation can rehabilitate patients and create many psychological rewards for patients and their families. Public health journals and referring physicians have criticized the use of public funds for the expensive technology of transplantation, particularly on the grounds that these patients are not well rehabilitated and are psychological cripples.

The testimonials in this book challenge the idea that kidney transplantation is a traumatic experiment rather than a viable therapy. The more prosaic statistics also challenge the criticisms: 72 percent of patients receiving kidneys from related donors have functioning grafts at the end of two years, as do 46 percent of patients receiving cadaver kidneys. Running through the stories is the theme of rebirth, of an exhilarating new life in which existence is more fully experienced after a close call with death and after a successful transplant.

Many of the patients had received their transplants 4, 6, 7, and in one case 13 years before the symposium. Furthermore, the related donors generally regarded the experience as a highly positive one. Parents who had faced the decision of allowing their child to die or taking the risk of transplantation and donation exulted in their active, healthy, growing children.

In terms of educating the professional, this volume may be particularly useful for those with little experience with transplant patients. The case histories are typical of patients who have successful courses. The horrors of being ill with terminal kidney disease are described with more vividness than any outsider could muster. For those professionals with more experience with this type of patient, other sources might be more useful in outlining the psychiatric problems of the patients, their families, and the staff (e.g., the February 1971 issue of *Seminars in Psychiatry*, titled "Psychiatric Aspects of Organ Transplantation"). Particularly interesting in this book are the articles by Douglas on the costs of transplantation, by Schreiner and Riteris on ethical considerations, and by Sadler on living unrelated donors.

There are some biases in the book that should be noted. First, there is a definite bias toward transplantation as opposed to dialysis. Proponents of dialysis might take issue with this. Second, the stories seem to emphasize only the successful aspects of posttransplant life. It is true that transplantation is most frequently successful. However, for the minority of patients for whom transplantation is unsuccessful, stress can be extreme. Some of the ordinary "successful" patients have problems that are almost untouched in these stories, although they were discussed at the symposium, e.g., the cushingoid "moonface," suicidal thoughts, and the side effects of cataracts, acne, and bone decalcification.

It is interesting that the following case history presented at the symposium is omitted from the book: a wife related the story of her husband's fourth transplant and his multiple complications, which included a cardiac arrest, a lung collapse, and a perforated abdomen. Also omitted is the careful documentation of risks to the donor presented by Dr. John Bergen at the symposium and any discussion of donor ambivalence.

In summary, this book makes excellent and interesting reading, particularly for those who are unaware of the successes of kidney transplantation and for those who are facing this therapy. The view presented is a real one, but somewhat biased in an optimistic direction. For the psychiatrist or social worker who wishes to help these patients, pretransplant stresses are more clearly depicted than posttransplant stresses.

ROBERTA G. SIMMONS, PH.D.
Minneapolis, Minn.

The Mind Possessed: A Physiology of Possession, Mysticism and Faith Healing, *by William Sargant. Philadelphia, Pa., J.B. Lippincott Co., 1974, 203 pp., $7.95.*

This most interesting book represents a continuation of Sargant's earlier work, *Battle for the Mind* (1), offering further documentation of possession phenomena to support his theory of brainwashing.

Sargant suggests that methods of thought reform, religious conversion, and psychotherapy all facilitate change by producing excessive cortical excitation, emotional exhaustion, and

states of reduced resistance, which, in turn, increase the patient's chances of being converted to new points of view. According to Sargant, such emotion-arousing activity, which is common in a variety of psychiatric settings as well as in the ritualistic practices typical of developed and developing societies, reduces resistance to change by freeing the individual from neurotic symptoms while introducing new ideals.

Sargant's methodical zeal to explore the phenomena of possession has taken him to the Sudan, Zambia, Nigeria, Dahomey, Brazil, Trinidad, Jamaica, Barbados, Haiti, and Appalachia. He has witnessed Zar possession, Macumba rites, voodoo, snake-handling cults, and revivalist sects. He recounts his experiences and observations with gusto in this book.

The array of accounts is impressive. Equally impressive is Sargant's effort to demonstrate the link between possession states and mesmerism, hypnosis, the effects of severe stress on the battlefield, sexual orgasm, and the use of drugs. Some may argue that the attempt to unify such dissimilar phenomena in terms of a single theory of nervous system excitation based on Pavlovian principles leaves little room for other theoretical considerations or for an examination of the subtle interrelationships among particular ceremonies, cultural contexts, and personality patterns. However, Sargant's orientation serves a definite purpose in providing us with a clearly stated perspective from which to examine such diverse phenomena.

We need to learn more about the differences in electroencephalographic response patterns as well as the role of metabolism in facilitating entry into such unusual mental states. For example, Adolf Meyer has suggested that the drug rhythms in some native rituals may induce states of possession by producing an auditory driving effect on the resting rhythms of the brain similar to the phenomenon of photic driving seen in photic epilepsy.

While Sargant neglects to consider the relationship between the common elements of possession phenomena and the social, cultural, and historical traditions in which they develop, he is to be commended for providing us with an impressive journalistic-scientific account in the tradition of many well-traveled English physicians. His book is most stimulating and—as always with Dr. Sargant—most provocative.

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ARI KIEV, M.D.
New York, N.Y.

Problem Drinking Among American Men. Monographs of the Rutgers Center of Alcohol Studies 7, *by Don Cahalan and Robin Room. New Brunswick, N.J., Rutgers Center of Alcohol Studies, 1974, 258 pp., $12.50.*

Problem Drinkers Seeking Treatment. Monographs of the Rutgers Center of Alcohol Studies 8, *by Eileen M. Corrigan. New Brunswick, N.J., Rutgers Center of Alcohol Studies, 1974, 79 pp., $6.00.*

These monographs are part of a series of 10 published by the Rutgers Center of Alcohol Studies. Other monographs in the series include *Alcohol and the Jews, Alcohol in Italian Culture, Drinking Among Teen-Agers,* and *The African Beer Gardens of Bulawayo.*

The subjects of *Problem Drinking Among American Men* are men aged 21 to 59 with drinking problems, drawn from two national surveys and from a community study in San Francisco. Cahalan and Room examine in detail the drinking habits of these men, the problems they experience as a result of drinking, and their socioeconomic characteristics.

The purpose of the study is to get a better idea of the epidemiology of alcoholism in the United States in an effort to understand, control, and perhaps prevent problem drinking in our society. The study itself is statistically involved and difficult to follow because of the complex variables that have to be considered in any analysis of drinking patterns.

The findings are what might be expected. In general, the men surveyed usually had more than one problem caused by their drinking. These problems ranged in increasing frequency and severity from troubles with the police, belligerency with others, job and financial problems, health problems, and quarrels with their wives to psychological dependency. Tangible consequences and problems related to heavy drinking occurred most often in the younger men, the poor, the ethnically disadvantaged, those with unstable work and marital records, and those exposed to heavy social drinking. It is not made clear whether these factors are causes or effects of heavy drinking.

The early life histories of these men indicate an unstable home environment, an alcoholic father, youthful acting out or impulsivity, alienation, and lack of ego resiliency during childhood.

Environmental factors associated with alcoholism are exposure to heavy social drinking, a rural background (especially from temperance-minded and "dry" communities), and a disadvantaged background.

Cahalan and Room do not come to any firm conclusions, but they do suggest further studies to determine more precisely the etiology of alcoholism, especially from the cultural standpoint. The important finding of this extensive study is that more attention should be given to the younger group of heavy-drinking American men. This group is the major progenitor of future alcoholism.

The eighth monograph in the Rutgers series, *Problem Drinkers Seeking Treatment,* is a unique and important contribution. Corrigan reports what happens to alcoholics who telephone, or have others telephone, an information or referral service for help. Three hundred such calls to the Information Bureau of the Community Council of Greater New York were followed up.

The findings show that this information and referral service does in fact perform a real service. Of the total number of callers, 54 percent of those for whom someone else called reached treatment, compared with 68 percent of those who made the call themselves. This suggests that alcoholics should be encouraged to initiate inquiries themselves.

Learning of the service through physicians, hospitals, or social agencies resulted in greater use of the resource. Subway, newspaper, and telephone-book notices were next in effectiveness and radio and television spots were least effective. More clients reached treatment when the referral center actively helped to arrange appointments. More than half of the clients who contacted the bureau got into and remained in treatment for at least 45 days.

Unfortunately, the treatment received by these clients often left much to be desired. The main treatment resources were general hospitals where the attention given alcoholics was often perfunctory and little effort was given to aftercare. About one-half of the clients referred to hospitals dropped out soon after the initial hospital contact.

Corrigan stresses the need for better alcoholism treatment programs in hospitals if the efforts of referral agencies are not to be wasted and the motivation of clients dissipated. She urges

referral sources to become more active in evaluating and upgrading treatment facilities in the community. Better treatment should be provided for those alcoholics seeking help.

FREDERICK LEMERE, M.D.
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Comparative Psychiatry: A Theoretical Framework, *by P.M. Yap, edited by M.P. Lau and A.B. Stokes. Buffalo, N.Y., University of Toronto Press, 1974, 110 pp., $10.00.*

Pow Meng Yap, one of the pioneers in Oriental cultural psychiatry, left his position at the University of Hong Kong in June 1971 to take up the newly created Chair of Transcultural Psychiatry at the University of Toronto. He died suddenly in November 1971.

This work, which has been edited and revised by two of his colleagues in Toronto, is a presentation of the knowledge Yap had accumulated over many years as well as a memento to his lifelong dedication to Far Eastern psychiatry. The book is titled *Comparative Psychiatry*, in contrast to "comparative psychiatric sociology." Yap defines the former as "that branch of transcultural psychiatry which is concerned mainly with clinical presentation [of mental illness] in different cultural settings."

The book is an attempt to establish a theoretical framework within which all the facts that we possess about mental disorder anywhere in the world can be encompassed and interrelated. By studying similarities and differences in the comparative phenomenology of illnesses transculturally, Yap sought to discover universal regularities of form and process. He aimed at understanding biopsychological and sociocultural variables in psychiatric illness. His wide approach encompasses such issues as the harmony of biological and sociological viewpoints, the differentiation of illness from deviancy, the problems of the sick role, communal belief, and the relating of brain to mind and thence to social gestalt. To attain these objectives he tries in this book to synthesize ideas drawn from such fields as psychoanalysis, general systems theory, neural theories, learning theory, ethology, role theory, and folk customs.

Yap's conclusions may be summarized as follows: 1) abnormal functioning is one extreme of a continuum of behavior grading into the normal at the other extreme; 2) a pattern of behavior must be regarded as abnormal even if it is manifested or supported by a large subgroup of a community; 3) there is a basic commonality in the mental diseases found in different cultural settings; and 4) judgment should be drawn from one of two levels, biological or sociopsychological, depending on which is more meaningful.

Chapter 8, "Nosological Aspects of the Culture-Bound Syndromes," introduces a practical note. Such disorders as koro, susto, latah, and amok are dealt with. Yap offers a classification of these syndromes. While they may manifest themselves in a highly stereotyped form when acute, their symptomatology may change with changes in society, its mores, and Zeitgeist. "Thus," he states, "the study of comparative psychiatry as an asynchronic discipline leads us theoretically to problems of historical change." He believed that treatment of these syndromes consists of shared sentiments and customary patterns of action, which are intimately bound up with the structure and content of the illness treated.

Yap's book is rich in content but heavy in style. It is instructive, interesting, and stimulating. It shows its author's erudition. However, Yap's very wide approach inevitably results in misrepresentation in some areas and oversimplification in others. Had he lived longer, Yap might have revised some of his formulations. He states in the preface, "This monograph is more an essay than a fully argued scientific treatise, but the subject demands a synthetic, many-disciplined approach which at times may appear superficial if not idiosyncratic to the specialist in a particular field."

E.D. WITTKOWER, M.D.
Montreal, Que., Canada

The Arctic Hysterias of the North Alaskan Eskimo, *by Edward F. Foulks. Washington, D.C., American Anthropological Association, 1972, 159 pp., $6.00; $3.00 (paper).*

"Arctic hysteria," which is presumably an exotic form of mental illness, was reported by some of the early explorers and ethnographers of Canada, Alaska, and northern Greenland. In the field of cross-cultural psychiatry it has come to be thought of as a culture-specific mental illness. This means it has been put forth as a unique pattern of behavior understandable only in terms of Eskimo culture. Interest in this phenomenon has been heightened by the fact that the Museum of Natural History, Washington, D.C., exhibits a collection of pictures from Perry's 1907 expedition that show an Eskimo woman going through an episode involving her mimicking local animals, falling into a convulsion, and demonstrating carpopedal spasms, body trembling, and exhaustion.

Although a number of people have tried to determine the pattern and prevalence of Arctic hysteria from the existing data and have developed theories to account for it, the effort reported in this new book is, as far as I know, the only all-out search for the phenomenon in contemporary Eskimo society. The author is a psychiatrist; this volume is the end product of his further training as an anthropologist. His goal was to test the hypothesis that Arctic hysteria can best be understood from an interdisciplinary perspective. The search and the goal could hardly be more laudable, but I suspect that the value of the endeavor is mainly unintended.

The search revealed that the Arctic hysterias are rare (10 cases were found among the 11,000 Innuit Eskimos of northern Alaska). The few people said to suffer from the disorder were exceedingly heterogeneous: "Several subjects had epilepsy; several were diagnosed as schizophrenic; most had low normal serum calcium levels; and one had hypomagnesemia and possible alcoholism" (p. 117).

The fact that arctic hysterias are uncommon, ill-defined, and mixed up with other things raises doubt about the utility of taking up the elaborate and, to my mind, questionable and unsupported set of hypotheses that form the major portion of the book. The theory is that Arctic hysteria results from the interlinking of environmental, physiological, psychological, and cultural factors.

The bioenvironmental mechanisms concern irregularity of light and dark periods and of the natural food resources of the Arctic. These are thought to contribute to abnormalities of calcium metabolism that in turn predispose to the periodic alteration of consciousness seen in Arctic hysteria. The psychocultural mechanisms include the Eskimo traditions, which involve models of seizure behavior on the part of shaman medicine men and the cultural use of ridicule as a means of social control, producing shame rather than guilt. It is suggested that if guilt were the characteristic response to negative sanction, one would find a high prevalence of depression. The Eskimo emphasis on shame, however, is conducive to periodic outlets in the conversion-type behavior of Arctic hysteria.

The flaws in this theory, as well as the faults in research de-

sign, measurement, and interpretation, are legion. The exposition of the theory is the intended purpose of the study and in this respect I believe the effort is largely a failure. I will mention three points.

First, the theory is so complex that it could not possibly be credited or discredited in the light of the very small sample of people found to have Arctic hysteria.

Second, some of the assumptions are neither self-evident nor evidenced in the usual sense of scientific demonstration. It is asserted, for example, that ridicule is the primary means of social control used by Eskimos. It is further asserted that the use of ridicule produces a psychological state called shame. The shame-guilt theme is popular in cross-cultural psychiatry, but I find no convincing evidence for it here or elsewhere. It would be helpful if attempts were made to clarify and measure these phenomena in different cultures and to count and compare the distributions. Until that is accomplished, the ethnographic statement that one culture is shame-ridden and another guilt-ridden seems to lead to a "standardization of error."

A third weakness of the book is the juxtaposition of highly refined, measured variables such as serum calcium levels and totally unmeasured variables such as degree of exposure to shamanism. The presumption seems to be that some indication of the influence of the latter as a model could be derived.

Probably the most important unintended value of this book is the chapter on the current use of mental hospitals among the population studied. It clearly indicates that alcoholism and depression are the most common and serious mental health problems that beset Eskimos. The hidden message is that scholars and practitioners should turn their attention to these and let the obscure hysterias be laid to rest with the publication of this volume.

JANE M. MURPHY, PH.D.
Boston, Mass.

Drug Abuse in Industry: Growing Corporate Dilemma, *edited by Jordan M. Scher, M.D. Springfield, Ill., Charles C Thomas, 1973, 303 pp., $11.95.*

This uneven collection of presentations is valuable principally because it illustrates the heightened interest of employers and professionals in the work adjustment of people who have problems of drug abuse. There has been a spate of monographs and papers on the subject in the past five years. *Drug Abuse in Industry* is illustrative of the genre of many recent books.

The volume is organized into seven parts. Following four introductory chapters, parts 2 and 3 focus on the impact of the drug abuser in a work setting. Part 4 is concerned with law and drug abuse, part 5 with rehabilitation, part 6 with the alcoholic, and part 7 with "special problems."

One finds a wide range of attitudes, from expressions of pride that pharmaceutical manufacturers have long had a policy not to hire any applicant with *any* record of drug abuse or suspected drug abuse to expressions of sympathetic support of vocational rehabilitation for those in treatment programs. These papers generally appear to be addressed to the employer.

It is unfortunate that many chapters reflect stereotypical and generally unscientific points of view as well as efforts to frighten the reader into taking some form of action in his company or institution. Most of the action suggested, however, is geared toward excluding the drug abuser from successful work.

The book is curiously unfocused; the chapters are not integrated into a cohesive whole. There are drum-beating statements such as "Each addict steals fifty to one hundred fifty thousand dollars worth of merchandise, equipment, or funds each year from business and industry." One may also find specific experiences of employers such as the Metropolitan Life Insurance Co., the American Telephone and Telegraph Co., and the Lockheed Aircraft Corp. that suggest otherwise. There is an excellent summary by Stephen Levy on the work experiences of heroin addicts and by Charles Winick on treatment priorities.

Although not mentioned in the book, the experience of many employers in the larger metropolitan areas is that the disruptive effect of narcotic addicts is on the wane. Since 1972, fewer and fewer new cases have come to the attention of the medical departments of work organizations. This note of optimism is nowhere seen in these pages.

ALAN A. MCLEAN, M.D.
New York, N.Y.

Uppers and Downers, *edited by David E. Smith, M.D., and Donald R. Wesson, M.D. Englewood Cliffs, N.J., Prentice-Hall, 1974, 151 pp., $2.45 (paper).*

This is a somewhat exasperating book. It is a collection of 11 papers of varying excellence and, as stated in the introductory chapter, of diverse and even conflicting views. Most of the papers were originally published in the *Journal of Psychedelic Drugs* and, at times, they are quite repetitive and redundant.

It is also difficult to guess for what readership the book is intended. Some sections are highly technical and scholarly; others are frankly political and certainly not intended exclusively for a physician audience. If it is intended for a nonprofessional readership, much of the content is too technical, e.g., the discussion of the pharmacology of amphetamines and barbiturates. However, one would have to assume from the title that it was intended for nonprofessional or paraprofessional mental health workers who deal with the problems of drug abuse. The inclusion of a glossary of drug terms strengthens this impression.

The foreword sets forth the purpose and philosophy of the book. I am in full accord with both. The heroin problem has certainly been exaggerated, the alcohol problem has been vastly underrated, and the growing and serious problems of the sedative and stimulant drugs have been largely ignored by the medical profession and the pharmaceutical industry. The writers in this book set forth their own theories as to why this is so. They argue that political and economic factors are paramount, casting little credit on the pharmaceutical establishment, the state and federal bureaucracies, the AMA, and APA. The authors are right in feeling that something ought to be done, but their proposals are somewhat simplistic and tend to be naïve.

The two editors and several of their collaborators have been active in the Haight-Ashbury Free Medical Clinic in San Francisco. They have observed at close range many of the clinical phenomena they describe so vividly in this book. One of the best chapters is on cocaine; it includes a discussion of Freud's experience with the drug. Another good article concerns the medical-legal view of amphetamines, written by John C. Kramer and Robert G. Penco. An interesting chapter is by Mike Gravel, U.S. Senator from Alaska, who mounts a rather aggressive attack on the AMA and physicians in general for their apparent indifference to what he considers the unethical action on the part of the pharmaceutical industry in promoting drugs that can be abused.

The final chapter is a typical essay by Thomas S. Szasz. He takes the position that an adult should be free to use any sort of drug or medication on himself as he sees fit. Dr. Szasz is a most

engaging debater. One ends up almost convinced that he believes what he says. This chapter is certainly out of place with the other chapters in the book, which are concerned with methods for preventing the abuse of drugs. In them we read time and again that the example of adults is one of the primary mechanisms by which the problem spreads into the juvenile population. Yet Szasz says let the adults do it but do not permit the children to do so. I, for one, must assume that he knows better than that.

This is a short book and has much in it to be commended. For the price and the time that it takes to read it, it is worthwhile. One is reminded that in an earlier time another Smith and Wesson helped "clean up the West" and bring order out of chaos. Perhaps this Smith and Wesson can help bring some order out of the present chaos of the drug problem.

GRANVILLE L. JONES, M.D.
Summit, N.J.

Life History Research in Psychopathology, vol. 2, *edited by Merrill Roff, Lee N. Robins, and Max Pollack. Minneapolis, Minn., University of Minnesota Press, 1972, 280 pp., $10.00.*

This book is an edited collection of 17 papers given at the third and fourth annual conferences of the newly formed multidisciplinary Society for Life History Research in Psychopathology. The book compiles progress reports on large-scale research programs collected into five sections pertaining to childhood, juvenile delinquency, the family, adulthood, and specific methodologies. The common threads are reliance on longitudinal study, study of congenital and environmental interactions, and careful definition of psychopathology.

The clinical populations studied cover much of the domain of psychopathology: addictions, affective disorders, alcoholism, behavioral problems in children, delinquency, psychopathic personalities, psychosomatic problems, schizophrenia, problems of the socially disadvantaged, and suicide risk are considered in research involving large numbers of subjects.

The authors of each article have clinical experience commensurate with their research sophistication. However, these clinical concerns are more fully revealed in the discussion sections appended to each chapter than in the formal papers. Many of the chapters include brief case histories to illustrate concepts; these are helpful in a book constructed around methodological advances and reports of findings.

New ways of approaching investigation and new thoughts about old concepts are presented throughout the book. Some widely held beliefs are discredited or questioned. Vaillant and McArthur question the value of the concept of "organ weakness" in psychosomatic illness. Munoz, his coworkers, and his discussants advocate dropping from usage the term "simple schizophrenia." The Dohrenwends find that cases of hardship among those accorded lower socioeconomic status are not best attributed to environmental stresses but to the personal style of "losers." Roff also focuses on class; he finds that rebellion against status deprivation is not an adequate account of delinquency among boys in the lower socioeconomic class.

A most satisfying set of papers indicates better outcomes than one might ordinarily expect for difficult populations, e.g., a paper on untreated juvenile delinquents by Roff, on narcotic addicts by O'Donnell, on alcoholics by Knupfer, and on children with a variety of behavioral problems by Chess and Thomas. This set of papers offers pleasant surprises to the stale impression that we fight a losing battle with these populations.

Methodological advances are reported throughout the book as well as in the separate section on procedures. Of particular interest is Robins' study, in which actuarial procedures were employed to estimate the causal influence—as opposed to the mere association—of one life event on another. Equally impressive are the advances made with the mental health case register described by Babigian. New assessment techniques for prediction of delinquency are described by Wirt and associates and a set of interview questions sensitive to suicide intentions is reported by Hudgens and his colleagues.

The appeal of this volume is increased by succinct historical reviews in several chapters. Garmezy's introduction discusses the various models of study used to consider etiology. He sets the stage for an appreciation of the old and new climates that make the first few years of these life history societies exciting. The reflections of Schulsinger on the history of the concept of psychopathy and those of Stott on the nature-nurture issue complement Garmezy's paper.

These authors agree that the climate from which we come is decidedly environmentalistic. Heavy emphasis is also placed on congenital influences to offset the old orientation, with the goal of a synthesis. Some of the papers offer splendid demonstrations of genetic influences, e.g., Schulsinger's study of psychopaths, which used adoptive controls, and Schuckit and associates' research on alcoholism, which used half-sibling controls. Cadoret helps tighten the case for a unipolar and bipolar distinction in depression and offers fresh evidence for a genetic explanation.

The papers in this volume are exciting references worth the time of the practitioner or researcher involved with the psychopathological populations considered here. The book can be safely recommended.

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Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

A Primer of Child Psychotherapy, *by Paul L. Adams, M.D. Boston, Mass., Little, Brown and Co., 1974, 195 pp., $9.95 (paper).*

The Emotionally Disturbed Family and Some Gratifying Alternatives, *by Ernest E. Andrews. New York, N.Y., Jason Aronson, 1974, 242 pp., $10.00.*

Becoming a Psychotherapist: A Clinical Primer, *by Rosemary Marshall Balsam, M.B., and Alan Balsam, M.D. Boston, Mass., Little, Brown and Co., 1974, 308 pp., $12.50 (paper).*

Annales de Thérapeutique Psychiatrique, vol. V: Études de psychopharmacologie, psychosociologie et psychothérapie clinique, *published by Henri Baruk. Paris, France, Presses Universitaires de France, 1974, 376 pp., no price listed.*

Retreat from Sanity: The Structure of Emerging Psychosis, *by Malcolm B. Bowers, Jr., M.D. Baltimore, Md., Penguin Books, 1974, 238 pp., $2.25 (paper).*

The Psychology of Human Ageing, *2nd ed., by D.B. Bromley. Baltimore, Md., Penguin Books, 1974, 416 pp., $2.95 (paper).*

Law, Psychiatry and the Mental Health System, *by Alexander D. Brooks. Boston, Mass., Little, Brown and Co., 1974, 1,143 pp., $22.50.*

Rape: Victims of Crisis, *by Ann Wolbert Burgess, R.N., D.N.Sc., and Lynda Lytle Holmstrom, Ph.D. Bowie, Md., Robert J. Brady Co. (Prentice-Hall), 1974, 308 pp., $8.95; $5.95 (paper).*

Strategic Intervention in Schizophrenia: Current Developments in Treatment, *edited by Robert Cancro, Norma Fox, and Lester E. Shapiro. New York, N.Y., Behavioral Publications, 1974, 302 pp., $14.95.*

Illustrated Diagnosis of Localized Diseases, *by R. Douglas Collins, M.D. Philadelphia, Pa., J.B. Lippincott Co., 1974, 212 pp., $34.00.*

The Grammar of Living, *by David Cooper. New York, N.Y., Pantheon Books (Random House), 1974, 151 pp., $6.95.*

Social Aspects of the Medical Use of Psychotropic Drugs. International Symposia on Alcohol and Drug Addiction 2, *edited by Ruth Cooperstock. Toronto, Canada, Alcoholism and Drug Addiction Research Foundation of Ontario, 1974, 176 pp., $10.00; $6.50 (paper).*

The Ordeal of Civility: Freud, Max, Lévi-Strauss, and the Jewish Struggle with Modernity, *by John Murray Cuddihy. New York, N.Y., Basic Books, 1974, 263 pp., $11.95.*

Counseling High School Students: Special Problems and Approaches, *edited by John G. Cull, Ph.D., and Richard E. Hardy, Ed. D. Springfield, Ill., Charles C Thomas, 1974, 251 pp., $10.75.*

Deciding on Divorce: Personal and Family Considerations, *edited by John G. Cull, Ph.D., and Richard E. Hardy, Ed.D. Springfield, Ill., Charles C Thomas, 1974, 154 pp., $8.50.*

Schizophrenics in the New Custodial Community: Five Years After the Experiment, *by Ann E. Davis, Simon Dinitz, and Benjamin Pasamanick. Columbus, Ohio, Ohio State University Press, 1974, 206 pp., $12.00.*

The Behavioral Treatment of Psychotic Illness: Advances in Theory and Technique, *edited by William J. DiScipio, Ph.D. New York, N.Y., Behavioral Publications, 1974, 231 pp., $12.95.*

Stressful Life Events: Their Nature and Effects, *edited by Barbara Snell Dohrenwend and Bruce P. Dohrenwend. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 331 pp., $19.95.*

Psychiatry Examination Review, *by William M. Easson, M.D. New York, N.Y., Arco Publishing Co., 1974, 156 pp., $8.00 (paper).*

Humanistic Psychotherapy: The Rational-Emotive Approach, *by Albert Ellis, Ph.D., edited by Edward Sagarin, Ph.D. New York, N.Y., McGraw-Hill Book Co., 1974, 268 pp., $2.95 (paper).*

The Development of a Child Psychiatric Treatment Program, *by Helen K. Grace. Cambridge, Mass., Schenkman Publishing Co. (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 224 pp., $12.50.*

Psychoneuroendocrinology. Proceedings of the Workshop Conference of the International Society for Psychoneuroendocrinology, Mieken 1973, *edited by N. Hatotani. New York, N.Y., S. Karger, 1974, 312 pp., $49.00.*

On Behalf of Children, *by William Hetznecker, M.D., and Marc A. Forman, M.D. New York, N.Y., Grune & Stratton, 1974, 223 pp., $9.75 (paper).*

Themes and Variations in European Psychiatry: An Anthology, *edited by Steven R. Hirsch, B.A., M.Phil., M.D., and Michael Shepard, D.M., D.P.M. Charlottesville, Va., University Press of Virginia, 1974, 429 pp., $20.00.*

Health and the Social Environment, *edited by Paul M. Insel and Rudolf H. Moos. Lexington, Mass., Lexington Books (D.C. Heath and Co.), 1974, 454 pp., $15.00.*

Creativity, Imagination, Logic: Meditations for the Eleventh Hour, *by Horace M. Kallen. New York, N.Y., Gordon and Breach, 1973, 212 pp., $14.50.*

Edward J. Kempf: Selected Papers, *edited by Dorothy Clarke Kempf, M.D., and John C. Burnham, Ph.D. Bloomington, Ind., Indiana University Press, 1974, 396 pp., $15.00.*

Factors in Depression, *edited by Nathan S. Kline, M.D. New York, N.Y., Raven Press, 1974, 268 pp., $16.95.*

Problems in Psychotherapy: An Eclectic Approach, *edited by Walter G. Klopfer and Max R. Reed. Washington, D.C., Hemisphere Publishing Co. (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 170 pp., $11.95.*

Threes and Fours Go to School, *by Sylvia Krown. Englewood Cliffs, N.J., Prentice-Hall, 1975, 232 pp., $7.95.*

The Conscience: A Structural Theory, *by M. Kroy. New York, N.Y., Halsted Press (John Wiley & Sons), 1974, 223 pp., no price listed.*

Transformation and Identity: The Face and Plastic Surgery, *by Frances Cooke Macgregor. New York, N.Y., Quadrangle/New York Times Book Co., 1974, 217 pp., $8.95.*

Nightmares and Human Conflict, *by John E. Mack, M.D. Boston, Mass., Houghton Mifflin Co., 1974, 243 pp., $3.45 (paper).*

True Americanism: Green Berets and War Resisters. A Study of Commitment, *by David Mark Mantell. New York, N.Y., Teachers College Press, 1974, 285 pp., $10.00; $5.95 (paper).*

The Actuarial Use of the MMPI with Adolescents and Adults, *by Philip A. Marks, Ph.D., William Seeman, Ph.D., and Deborah L. Haller. Baltimore, Md., Williams & Wilkins Co., 1974, 310 pp., no price listed.*

Street Drug Analysis and Its Social and Clinical Implications. International Symposia on Alcohol and Drug Addiction 1, *edited by Joan A. Marshman. Toronto, Canada, Addiction Research Foundation of Ontario, 1974, 115 pp., $8.00; $5.50 (paper).*

Current Psychiatric Therapies, vol. 14, *edited by Jules H. Masserman, M.D. New York, N.Y., Grune & Stratton, 1974, 272 pp., $21.50.*

Genetics, Environment and Psychopathology, *edited by Sarnoff A. Mednick, Fini Schulsinger, Jerry Higgins, and Brian Bell. New York, N.Y., American Elsevier Publishing Co., 1974, 339 pp., $19.20 (paper).*

They Chose Honor: The Problem of Conscience in Custody, *by Lewis Merklin, Jr., M.D. New York, N.Y., Harper & Row, 1974, 325 pp., $8.95.*

Psychiatric Illness: Diagnosis, Management and Treatment for General Practitioners and Students, *2nd ed., by H. Merskey, M.A., D.M., and W. Lawton Tonge, M.D. London, England, Baillière Tindall (Baltimore, Md., Williams & Wilkins Co., exclusive U.S. agents), 1974, 284 pp., $11.50 (paper).*

Psychic Exploration: A Challenge for Science, *edited by Edgar D. Mitchell and John White. New York, N.Y., G.P. Putnam's Sons, 1974, 696 pp., $17.50.*

Brain Dysfunction in Metabolic Disorders. Association for Research in Nervous and Mental Disease, vol. 53, *edited by Fred Plum, M.D. New York, N.Y., Raven Press, 1974, 315 pp., $21.50.*

Between Belief and Unbelief, *by Paul W. Pruyser. New York, N.Y., Harper & Row, 1974, 286 pp., $10.00.*

Predictable Pairing: The Structures of Human Atoms, *by Robert A. Ravich, M.D., and Barbara Wyden. New York, N.Y., Peter H. Wyden, 1974, 280 pp., $8.95.*

The Psychology of Anomalous Experience: A Cognitive Approach, *by Graham Reed. Boston, Mass., Houghton Mifflin Co., 1974, 169 pp., $2.95 (paper).*

Explorations in Psychiatric Sociology, *edited by Paul M. Roman and Harrison M. Trice. Philadelphia, Pa., F.A. Davis Co., 1974, 207 pp., $11.95.*

Sociological Perspectives on Community Mental Health, *edited by Paul M. Roman and Harrison M. Trice. Philadelphia, Pa., F.A. Davis Co., 1974, 247 pp., $11.95.*

Essays in Creativity, *edited by Stanley Rosner and Lawrence Edwin Abt. Croton-on-Hudson, N.Y., North River Press, 1974, 209 pp., $15.00; $4.95 (paper).*

The Problem Oriented Record in Psychiatry and Mental Care, *by Ralph S. Ryback, M.D. New York, N.Y., Grune & Stratton (Harcourt Brace Jovanovich), 1974, 189 pp., $12.50 (paper).*

Psychopathology: Learning Theory, Research, and Applications, *by Jack Sandler and Robert S. Davidson. New York, N.Y., Harper & Row, 1973, 356 pp., no price listed.*

Anticipatory Grief, *edited by Bernard Schoenberg, Arthur C. Carr, Austin H. Kutscher, David Peretz, and Ivan K. Goldberg. New York, N.Y., Columbia University Press, 1974, 374 pp., $12.50.*

Ethnic Groups of America: Their Morbidity, Mortality and Behavior Disorders, vol. II. The Blacks, *edited by Ailon Shiloh and Ida Cohen Selavan. Springfield, Ill., Charles C Thomas, 1974, 279 pp., $17.50; $12.95 (paper).*

Guide to Psychiatry, *3rd ed., by Myre Sim, M.D., D.P.M. London, England, Churchill Livingstone (New York, N.Y., Longman, distributor), 1974, 1,191 pp., $21.00.*

How to Really Know Yourself Through Your Handwriting, *by Shirl Solomon. New York, N.Y., Bantam Books, 1974, 193 pp., $1.95 (paper).*

The Realization of Death: A Guide for the Psychological Autopsy, *by Avery D. Weisman, M.D. New York, N.Y., Jason*

Aronson, 1974, 201 pp., $10.00.

The Open Token Economy System: A Handbook for a Behavioral Approach to Rehabilitation, *by Michael W. Welch, M.A., and Jerre W. Gist, M.A. Springfield, Ill., Charles C Thomas, 1974, 183 pp., $13.75.*

WHO Expert Committee on Drug Dependence: Twentieth Report. WHO Technical Report Series 551, *by the World Health Organization. Geneva, Switzerland, WHO (Albany, N.Y., Q Corp., distributor), 1974, 89 pp., 7 Swiss francs (paper).*

Every Day Gets a Little Closer: A Twice-Told Therapy, *by Irvin D. Yalom, M.D., and Ginny Elkin. New York, N.Y., Basic Books, 1974, 244 pp., $8.95.*

Amicus Curiae Brief in the Donaldson Case

*The amicus curiae brief of the American Psychiatric Association is published here both to emphasize a momentous historical event in psychiatry and to share with the membership the substantive thinking that went into APA participation. This brief asked the Supreme Court of the United States to rule on the right to treatment of the mentally ill and the legal responsibility of psychiatrists as to that right. The Supreme Court has agreed to accept the case; this marks the first time in the history of the United States that its highest tribunal has considered the rights of the noncriminal mentally ill. It will also be the first instance that the court will be considering the rights and duties of the psychiatrists who attend those patients. The APA brief asks the court to do justice to both patients and physicians.**

ALAN A. STONE, CHAIRMAN
APA COMMISSION ON JUDICIAL ACTION

**The preparation of this brief was complicated by the fact that in recent years APA has been reluctant to promulgate minimum doctor-patient ratios and other minimum personnel standards. One of the reasons for this reluctance has been the experience that minimal standards are all too often in legislative application converted to maximums. The brief therefore cites the last available official APA position, which has also been applied in other recent judicial determinations.

IN THE

Supreme Court of the United States

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner,*

v.

KENNETH DONALDSON, *Respondent.*

Brief of American Psychiatric Association as Amicus Curiae in Support of the Grant of Certiorari

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INTEREST OF AMICUS CURIAE

The American Psychiatric Association (A.P.A.), founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Almost 20,000 of the nation's approximately 25,000 psychiatrists are members of the Association. The A.P.A. has participated as an *amicus curiae* numerous times in cases throughout the country involving mental health issues.

Amicus believes this case to be of historic importance to the future of mental health care in the nation's public mental institutions. The landmark ruling below that there is a constitutional right to treatment, and the difficult question of how to enforce that right, are of immense concern to members of the A.P.A. and to their patients. A grant of certiorari here is essential in order to clarify presently conflicting interpretations of the rights and duties of mental patients and their psychiatrists.

CONSENT OF THE PARTIES

Amicus is filing this Brief with the consent of both parties, whose letters of consent have been filed with the Clerk.

ARGUMENT

The opinion below decides two questions that are fundamental to the future course of mental health care in this country. First, does the involuntarily committed patient at a state mental institution have a constitutional right to a level of treatment reasonably calculated to improve his or her mental condition? Second, assuming there is such a right, who should be responsible for providing the remedy when an institution has inadequate resources to provide that level of treatment?

The court below answered the first question by holding that there *is* a constitutional right to an adequate level of treatment, and that Respondent Kenneth Donaldson did not receive this minimum level of care. Amicus A.P.A. wholeheartedly supports the Court of Appeals decision on this issue. Indeed, as we will discuss in Part I, below, Amicus believes that the importance of this principle and the conflicts between the states as to its enforcement require a grant of certiorari here. An affirmance of the decision below on this point could provide invaluable guidance to the lower courts and to responsible state agencies by clarifying the contours of this new right to treatment.

Regarding the second major question—the proper remedy for violation of this new right—Amicus believes the court below committed a serious error. As we will discuss in Part II, below, the Court of Appeals has held that the psychiatrist who chooses to work for a woefully understaffed state mental institution can be held *personally* liable when a patient receives insufficient treatment, even though the institution has such inadequate resources that it would be impossible for its doctors to provide adequate care to all their patients. This ruling conflicts with numerous decisions from other courts holding that state officials are not liable personally for damages when in good faith they have been unable to comply with a newly declared constitutional right. Moreover, holding the doctor rather than the institution liable for damages will almost certainly deter psychiatrists from working at the institutions where they are most needed—those where the current level of treatment is the most inadequate. This Court should grant certiorari so that this ruling does not negate much of the potential for good inherent in the lower court's holding on the right-to-treatment issue.

I. THIS COURT SHOULD GRANT CERTIORARI HERE TO AFFIRM THE CONSTITUTIONAL RIGHT TO TREATMENT.

The present case starkly reveals the overwhelming shame and challenge of this nation's mental health care system. The deplorable conditions shown to exist at Florida State Hospital at Chattahoochee ("Chattahoochee") are all too common in many jurisdictions throughout the country. Legislatures and officials in numerous states routinely deny mental hospitals the resources needed to treat their involuntarily committed residents like patients, rather than like prisoners. This Court should grant certiorari so that all such institutions (and the legislatures that support them) will understand their legal duties and begin providing at least the basic minimum level of care that the Fifth Circuit has recognized is a constitutional requirement.

During Mr. Donaldson's fourteen-year confinement, the ratio of patients per staff psychiatrist ranged from 560-1 all the way up to 1000-1. Petition for Certiorari, at 6. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47% of his or her time to direct patient care.[1] Thus, if each doctor spent an equal amount of time with each patient, as little as one or two minutes per week would have been available for psychiatric "treatment" of each patient at Chattahoochee. Meaningful psychiatric care was not, and cannot be, provided under such circumstances.

[1] JOINT INFORMATION SERVICE, AMERICAN PSYCHIATRIC ASS'N & NAT'L ASS'N FOR MENTAL HEALTH, ELEVEN INDICES 14 (1971).

The American Psychiatric Association has promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care.[2] These are truly *minimun* standards, since they "represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized." Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIAT. 1, 7 (1958). Yet even these minimal standards, which have been accepted as guideposts by the courts, *see Rouse* v. *Cameron*, 373 F.2d 451, 457-58 & n.33 (D.C. Cir. 1966); *see also Wyatt* v. *Stickney*, 344 F. Supp. 373, 383 (M.D. Ala. 1972), *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972), demonstrate that Chattahoochee needed a vastly larger number of doctors than it actually had in order to provide adequate treatment to its resident population. The A.P.A. standards allow no more than thirty acutely ill patients, or 150 chronically ill patients, per full-time psychiatrist. Thus, while each psychiatrist at Chattahoochee averaged 750 patients, of whom 350 were acutely ill,[3] minimum staffing standards demanded *sixteen* full-time psychiatrists in order to treat those patients.

The necessity for a grant of certiorari here to affirm mental patients' constitutional right to treatment arises from the fact that state mental hospital overcrowding and understaffing are common today far beyond the confines of Chattahoochee or the Fifth Circuit. "In many of our hospitals about the best that can be done is to give a physical examination and make a mental note on each patient once a year, and often there is not even enough staff to do this much." Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIAT. 1, 7 (1958). A comprehensive report in the early 1960's suggested that no public mental hospital in the United States met minimum staffing requirements. U. S. SURGEON GENERAL'S AD HOC COMM. ON PLANNING FOR MENTAL HEALTH FACILITIES, PLANNING OF FACILITIES FOR MENTAL HEALTH SERVICES 39 (1961). Although there has been considerable improvement in recent years,[4] current studies continue to reveal many large mental hospitals with patient-doctor ratios of 500-1 and even higher.[5]

When institutional resources are so low, hospitals become indistinguishable from prisons. Patient "care" is little more than custody, and the treatment rationale for involuntary commitment becomes a cruel hoax. Like Kenneth Donaldson, there are many thousands of people throughout the country who, although suffering from serious mental illness, have committed no crimes and shown no obvious signs of dangerousness to others, *see* 493 F.2d at 517, but whom society has forced into mental institutions to receive treatment for their own good. This *"parens patriae"* rationale rings hollow, indeed, when "treatment" turns into neglect.

The court below was the first federal court of appeals to rule that involuntarily committed mental patients have a constitutional right to treatment. *See* 493 F.2d at 519 & n.9. A few courts have rejected the existence of such a right. *See, e.g., People ex rel. Anonymous* v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S. 2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962). More commonly, however, state officials simply assume that no such right exists when they make their staffing and resource decisions, and mental patients fail to bring any judicial action to challenge those decisions. This Court has already noted how infrequently mental patients litigate the states' powers in this area. *Jackson* v. *Indiana*, 406 U.S. 715, 737 (1972). Thus, because of the condition of the people whose rights are affected, conflicts between different states' policies and constitutional interpretations regarding the right to treatment do not necessarily result in a conflict between circuit court decisions. Nevertheless, the conflict is very real and very crucial to the citizens in many jurisdictions outside the Fifth Circuit who are being confined without constitutionally adequate treatment.

This Court should grant certiorari to resolve those conflicting state practices by affirming that there is a constitutional right to treatment.

[2] AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 61 (rev. ed. 1958).

[3] These figures are roughly the midpoints of the data range during the fourteen-year period for each category. *See* Petition for Certiorari, at 6-7.

[4] *See* NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972, at 7-9 (DHEW Pub. No. ADM 74-28, 1974).

[5] While the nationwide average patient-psychiatrist ratio in state mental hospitals is now down to approximately 70-1, *county* mental hospitals still average 500 patients per psychiatrist. *Id.* at 53. The range between the highest and lowest statewide patient-psychiatrist ratio (counting all of each state's public mental hospitals) is a staggering 14,300%, the worst state having 143 times more patients per doctor than the best state. *Compare* NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY HOSPITALS, UNITED STATES, 1973, at Table 1 (Aug., 1974) (Alabama), *with id.* at Table 1 (Colorado). Reports of individual mental hospitals with a thousand or more patients per psychiatrist are "well known." *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judic.*, 91st Cong., 1st & 2d Sess. 30, 51 (1969-70).

II. THE LOWER COURT'S STANDARD FOR PERSONAL LIABILITY CONFLICTS WITH THE PRINCIPLE OF PIERSON v. RAY AND WILL HAMPER ENFORCEMENT OF PATIENTS' RIGHT TO TREATMENT.

After concluding that there is a constitutional right to treatment, the Court of Appeals faced the equally important issue of determining the appropriate remedy for violation of that right. On this issue Amicus believes the lower court seriously erred. The record shows that at Chattahoochee there were so few doctors that it was impossible for them to provide adequate treatment to all their patients. *See* pp. 4-5, *supra*. Yet, the court held that those doctors who stay at the institution and try to treat the huge number of patients there can be liable *personally* for any damages the patients suffer from lack of treatment. This ruling is fundamentally unfair to the doctors and is contrary to the patients' interest in obtaining more medical treatment.

At least prior to this case, the law was well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even if those principles later were overturned. As this Court held in *Pierson* v. *Ray*, 386 U.S. 547, 557 (1967), state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry* v. *Fisher*, 309 F. Supp. 12, 17 (D. Me. 1970).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-520 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous* v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S.2d 728 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson* v. *O'Connor*, 234 So. 2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970). *See also Donaldson* v. *O'Connor*, 390 U.S. 971 (1968); *Donaldson* v. *Florida*, 371 U.S. 806 (1962); *In re Donaldson*, 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there should be a constitutional right to treatment. *Wyatt* v. *Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971), *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972).

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson* v. *Ray* to apply the right-to-treatment principle retroactively by holding Dr. O'Connor personally liable for damages. Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal doctrine." *Eslinger* v. *Thomas*, 476 F.2d 225, 229 (4th Cir. 1973). In *Eslinger*, plaintiff challenged the policy of the clerk of the South Carolina State Senate that women were ineligible to serve as senate pages. The Fourth Circuit held that injunctive relief was proper, since the discriminatory policy ran afoul of current constitutional requirements of equal protection. The court went on, however, to reverse the lower court's ruling that the clerk should be liable for damages. The court noted that the defendant's actions had taken place at a time when the law generally tolerated sex-based classifications. *Id.* at 230 & n.5. "Although the clerk may have acted with little sensitivity . . . he acted in the light of a long-standing, albeit vaguely defined, 'custom' . . . . He did no more, or less, than what had always been done." *Id.* at 229. The Fourth Circuit concluded that the defendant should not be liable for failing to foresee a new constitutional principle. *Id.; accord, e.g., Skinner* v. *Spellman*, 480 F.2d 539 (4th Cir. 1973) (no damages against official acting in "reasonable good faith reliance on what was standard operating procedure"); *Clarke* v. *Cady*, 358 F. Supp. 1156, 1163 (W.D. Wisc. 1973) (prison warden "immune from damages under § 1983 when he reasonably relies upon the validity of a prison practice which has only subsequently been determined to be unconstitutional"); *Collins* v. *Schoonfield*, 363 F. Supp. 1152, 1156 (D. Md. 1973) ("it would contravene basic notions of fundamental fairness if prison officials were held to be liable monetarily for acts which they could not reasonably have known were unlawful").

In the instant case, even if Dr. O'Connor had possessed the prescience to recognize Mr. Donaldson's constitutional right to adequate treatment, Amicus fails to see how Dr. O'Connor could have responded in a way that would have satisfied the court below. Petitioner had as many as *sixteen times* more patients than it was possible to treat properly under accepted professional standards. *See* pp. 4-5, *supra*. Moreover, Mr. Donaldson himself rejected for religious reasons [6] the medication therapy which is generally recognized as one of the most effective

[6] *See Winters* v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) (involuntarily committed Christian Scientist has right to refuse medication treatment). *See also Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1350 (1974).

forms of treatment for his condition.[7] Thus, the staff time and resources needed for adequate treatment of Mr. Donaldson simply were not available at Chattahoochee.

It is no answer to say, as did the Court of Appeals, that Dr. O'Connor should be personally liable because he did not devote as much time to Mr. Donaldson as did Dr. Hanenson, another one of Mr. Donaldson's attending physicians. *See* 493 F.2d at 518.[8] When only one or two minutes per week is available to "treat" each patient, see p. 4, *supra*, a doctor must either devote insufficient time to all patients, or give extra time to some at the expense of many others. The record shows that Dr. Hanenson decided to give a disproportionately large amount of his time to Mr. Donaldson—more time than any doctor at Chattahoochee possibly could devote to each of the 560-1000 persons for whom he or she was responsible. Under the Court of Appeals ruling, however, the extra attention a doctor gives to one patient can become the standard which every doctor in that institution must meet for every patient. Inevitably, to comply with such a rule doctors must provide identical amounts of time to each patient, regardless of levels of need. This "lowest common denominator" approach substitutes a mathematical rule for medical judgment. It ignores the harsh reality that even the sharpest knife cannot cut a small pie into enough servings to sustain 1000 starving people. The fact is that no matter how each doctor at Chattahoochee chose to divide it, his total time for patient care was just too small to go around.

It is an unspeakable tragedy when a mentally ill person is crowded into a facility like Chattahoochee, given little or no medical treatment, and allowed to remain there for years on end. Amicus believes strongly that such conditions violate the patient's constitutional right to treatment. The responsibility for a remedy, however, must lie with those who have the power to correct these conditions.[9]

The courts can find effective remedies for these problems by focusing on the institutional setting and resources available for treatment. In *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *on submission of proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972), the court has used its equitable power to require state institutions to increase their staff-patient ratio to the level necessary to provide adequate care. *See* 344 F. Supp. at 387. The American Psychiatric Association is participating in the *Wyatt* case, supporting the right to treatment and urging the court to order a variety of needed institutional reforms. *See* Motion of American Psychiatric Association for Leave to Participate as *Amicus Curiae*, *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., filed Dec. 4, 1972). The other right-to-treatment cases relied upon by the court below similarly focus on institutional reforms and injunctive relief. *See Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974); *Stachulak* v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973). *See also Rouse* v. *Cameron*, 373 F.2d 451, 458-59 (D.C. Cir. 1966) (institution must release patient receiving inadequate treatment). When a state institution fails to meet these minimum standards identified by the courts, a damage action should lie *against the responsible state agency*.[10] *See Whitree* v. *State*, 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (Ct. Cl. 1968) ($300,000 award against state for improper custodial confinement of mental patient). Indeed, such actions may be the most effective method to loosen the legislatures' pursestrings, so that sufficient resources do become available. *See* 82 HARV. L. REV. 1771, 1776-77 (1969).

Instead of such institutional remedies, the Fifth Circuit has held that the doctor who works on the staff of an overcrowded hospital is personally liable for damages to patients he or she is unable to treat. This decision has frightening implications for the very patients whose right to treatment the court was seeking to protect. Unless this Court grants certiorari it would be foolish for qualified doctors to continue working at Chattahoochee or the many other institutions that are similarly understaffed. Rather than stay in a system where their best efforts could not eliminate constant exposure to large damage awards, doctors will seek positions in private practice, or at the better-staffed institutions. Rather than increasing

[7] *See, e.g.*, Hollister, *Choice of Antipsychotic Drugs*, 127 AM. J. PSYCHIAT. 186, 188 (1970); VETERANS ADMINISTRATION, ANTIPSYCHOTIC, ANTIANXIETY & ANTIDEPRESSANT DRUGS 3 (MB-11, Sept. 15, 1966).

[8] Although the lower court paid lip service to the propriety of allowing doctors a "good faith" defense in cases of this kind, *see* 493 F.2d at 527, it effectively eliminated such a defense by ignoring the evidence that insufficient resources at Chattahoochee made adequate treatment impossible. *See* pp. 4-5, *supra*.

[9] Supporters of the right to treatment generally recognize that the understaffing and lack of physical facilities that plague our state mental institutions are not the fault of the psychiatrists or others who work there. "Our society should be grateful to, rather than adversely critical of, the personnel who continue to work in these institutions under the present trying conditions." Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 500 (1960); *accord, e.g.*, Birnbaum, *Some Remarks on the Right to Treatment*, 23 ALA. L. REV. 623, 628 (1971).

[10] The doctor should be personally liable, of course, if he commits any acts of malpractice. *See generally* Morse, *Tort Liability of the Psychiatrist*, 18 SYR. L. REV. 691 (1967).

the quality and quantity of treatment available at Chattahoochee, the decision below will lead to just the opposite result.

The Court of Appeals indicated in its opinion that the "core of the charge" against Dr. O'Connor was that he confined Mr. Donaldson "knowing that [he] was not receiving adequate treatment and knowing that absent such treatment the period of his hospitalization would be prolonged." 493 F.2d at 513. The tragic truth is that the grossly inadequate resources in our state mental hospitals today require many of our country's best psychiatrists in painful candor to confess their guilt to this same charge. The question this Court should review is whether our judicial system can help correct the institutional inadequacies that are depriving thousands of mental patients of their fundamental rights, or whether instead the judicial response will be to punish and drive away the people who are doing the most to deal with these problems.

CONCLUSION

For the foregoing reasons, Amicus respectfully urges this Court to grant a writ of certiorari.

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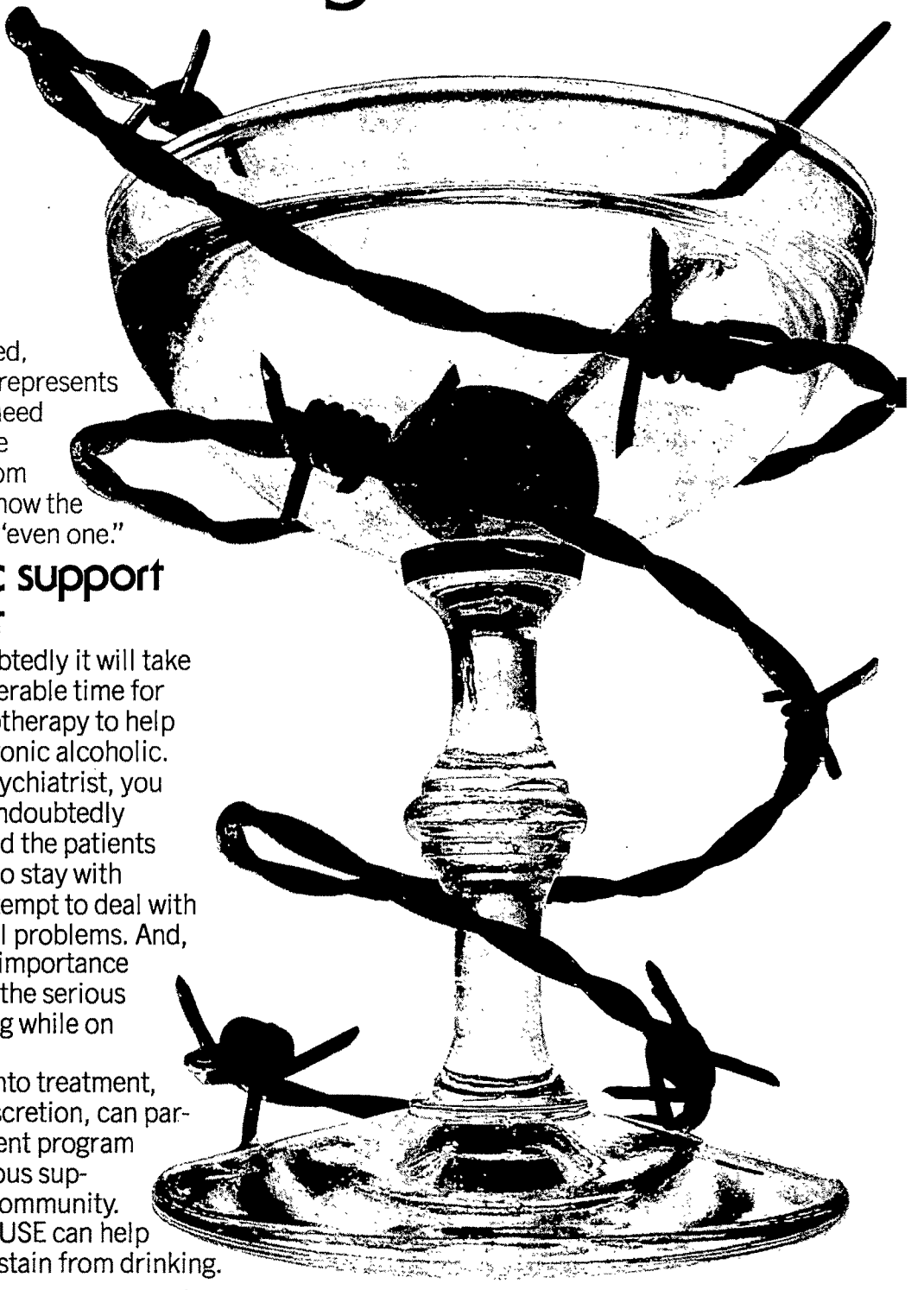
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CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g. cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE (disulfiram) should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE (disulfiram), report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupte administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even year

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

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New York, N.Y. 10017

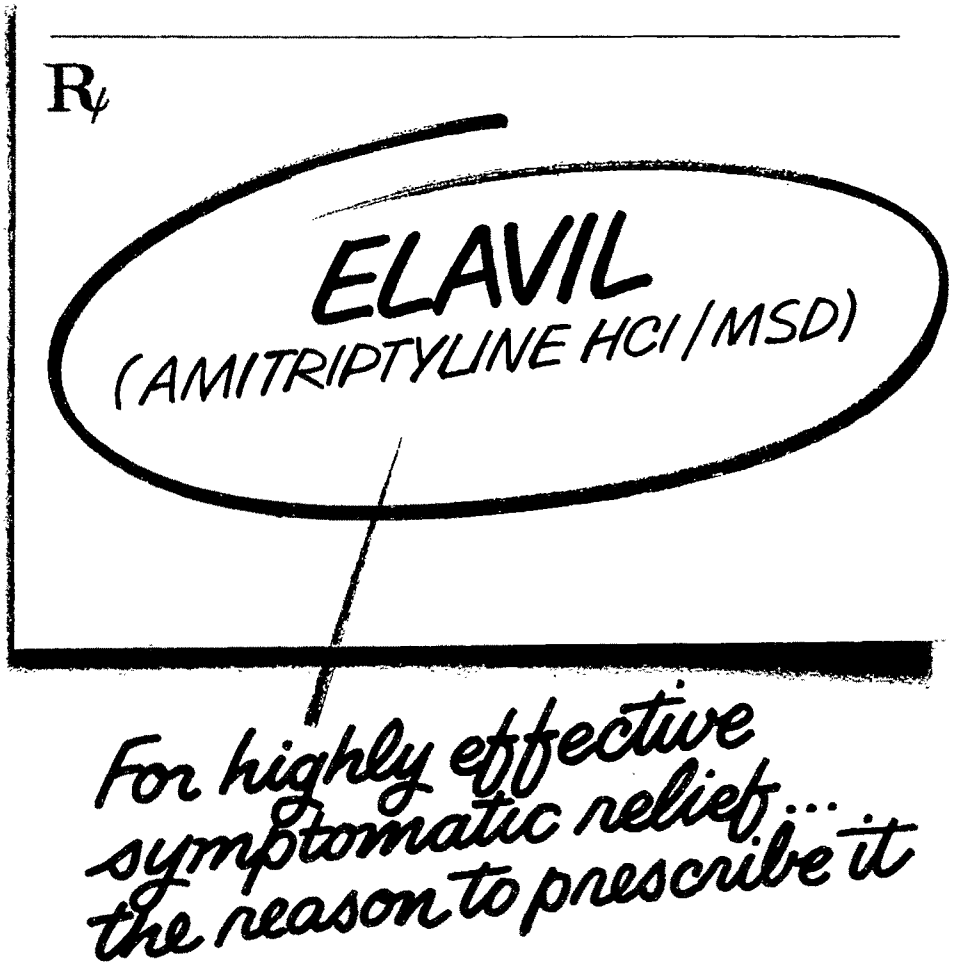
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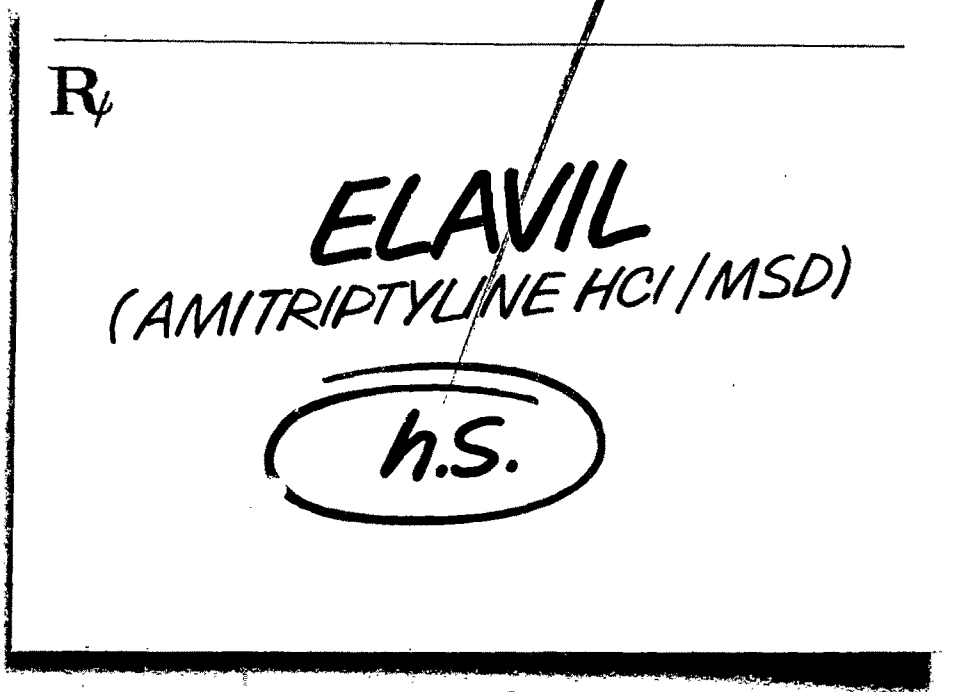
ANTABUSE®

BRAND OF DISULFIRAM

In the treatment of clinically significant depression...



Now added dosage versatility...



- **An important alternative in fitting the medication to the patient's needs**

  Once-a-day dosage at bedtime is an appropriate way to start—and maintain—many patients on therapy. Of course, ELAVIL may be administered two, three, or four times as well as once a day. This dosage versatility allows prescribing precisely for the patient's needs.

- **Once-a-day dosage schedule for adult outpatients**

  Therapy should be initiated with 50 mg to 100 mg at bedtime. This may be increased by 25 or 50 mg added to the bedtime dose as necessary to a maximum daily dose of 150 mg. The usual maintenance dose is 50 to 100 mg a day given at bedtime, though in some patients, 40 mg per day is sufficient.

- **Greater patient compliance**

  The simplicity of once-a-day dosage at bedtime makes it easier for patients to adhere to a regimen—an especially important consideration in depressed patients whose self-motivation may be at a low ebb.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

once a day at bedtime

Please see addendum on following page for other details of dosage and administration including divided daily doses, dosage in hospitalized patients, and dosage in elderly and adolescent patients.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

added dosage versatility in clinically significant depression

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



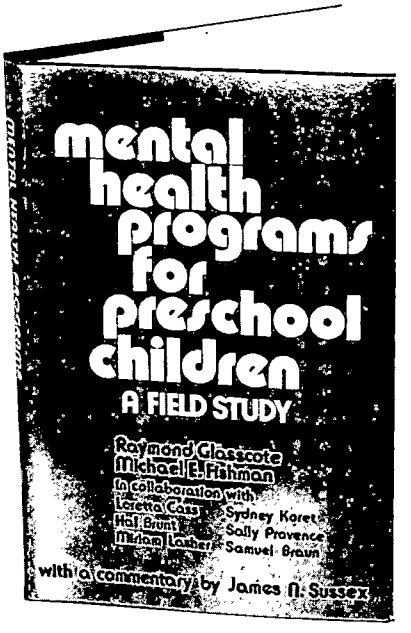
For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

A Timely New Book from The Joint Information Service

This latest Joint Information Service field study provides a concise, comprehensive overview of the complex matter of the very young American child and his mental health, and then describes in intimate detail seven unique programs for pre-school children with problems—from North Hollywood's Dubnoff Center, emphasizing education as its primary therapeutic modality, to Baltimore's Martin Luther King, Jr. Parent-Child Center, serving two housing projects, served by Johns Hopkins, and largely governed by its own people. All different in treatment approach and philosophy, the programs described are uniform in their dedication to innovation in improving service to the emotionally disturbed very young child, and, equally, to the emotional well being of all young children.

This thoughtful and perceptive description of what has been created by some of the best informed, most experienced and thoughtful specialists in mental health services for very young children should be welcome to all involved in the mental health of children and a casebook for those dealing with child and family mental health.



An articulate exposition of the immense problems and encouraging accomplishments in a particularly difficult area of endeavor . . . . Beyond their concern with the manifestly ill child, the authors intriguingly explore what may be needed to enhance the mental good health of all young children . . . . A significant contribution.

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175AJP

May be the start of a better life for the epileptic

About nine out of ten epileptics suffer their first seizure in childhood.[1] Certain physical and psychic postseizure evidence—a badly bitten tongue, broken or dropped objects, amnesia, exhaustion—may suggest grand mal. Once the diagnosis of epilepsy has been established, *MYSOLINE (primidone) may mean the start of a seizure-free life.*

Early therapy for control of grand mal, focal and psychomotor epilepsy. Used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. Based c years of clinical success, MYSOLINE has earn the reputation of being an *excellent* drug for cc trol of grand mal epilepsy.[2-4] But its usefulness not confined to this type alone: MYSOLINE h proved to be valuable for control of psychomotor and focal epilepsy[5] as well.

Improves response to concomitar therapy. When other anticonvulsants prove be inadequate, adding MYSOLINE to the regim can improve seizure control in grand mal and p



:homotor epilepsy. A double-blind comparative study[6] shows that the combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.

Effective changeover therapy. Unsatisfactory performance or important side effects may force discontinuation of the patient's existing anticonvulsant therapy. For more effective control, MYSOLINE may be added to the patient's present regimen, then gradually substituted for the original medication. The changeover to MYSOLINE is frequently warranted when grand mal is refractory to phenobarbital, with or without diphenylhydantoin.[7]

Mysoline®
[primidone]

See last page of advertisement for prescribing information.



Ayerst®

AYERST LABORATORIES
New York, N.Y. 10017

Mysoline® (primidone)
May be the start of a better life for the epileptic

initial and maintenance therapy for grand mal, psychomotor and focal epilepsy

BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of **PRIMIDONE**

Anticonvulsant

INDICATIONS: MYSOLINE, either alone or in combination, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Use in pregnancy: The effect of primidone on the human fetus has not been studied, and the benefit of administration of any drug during pregnancy must be weighed against any possible effect on the fetus.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking MYSOLINE and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K_1 therapy for one month prior to, and during, delivery.

In nursing mothers: There is evidence that in mothers treated with MYSOLINE, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone) and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	*2nd Week* 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	*4th Week* 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances: for initiation of combination therapy; during "transfer" therapy; for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.).

HOW SUPPLIED: MYSOLINE *Tablets*—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE *Suspension*—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluidounces.

References: 1. Livingston, S., and Pruce, I.: Pediatr. Ann. *2*:10 (Aug.) 1973. 2. Livingston, S., and Pruce, I.M.: Drug Therapy for Epilepsy, Springfield, Ill., Charles C Thomas, 1966, p. 23. 3. Scholl, M. L., in Conn, H. F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. *37*:49 (Jan.) 1970. 5. Forster, F. M.: Med. Clin. North Am. *47*:1579 (Nov.) 1970. 6. White, P. T.: Wis. Med. J. *68*:178 (Apr.) 1969. 7. Millichap, J. G.: Drug Ther. *1*:15 (Oct.) 1971.

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175AJP

Akineton® hydrochloride (biperiden hydrochloride) Tablets/Ampules

Contraindications: The only known contraindication is sensitivity to Akineton hydrochloride.

Warnings: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients.

Precautions: Caution should be observed in patients with manifest glaucoma, though no prohibitive rise in intraocular pressure has been noted following either oral or parenteral administration. Patients with prostatism or cardiac arrhythmia should be given this drug with caution. Occasionally, drowsiness may occur.

Adverse reactions: Adverse reactions encountered are primarily dry mouth and blurred vision. These side effects are usually slight and can be overcome by judicious reduction of dosage. If gastric irritation occurs, it can be avoided by administering during or after meals.

Dosage and Administration: Doses required to achieve therapeutic goal are variable and must be individually and gradually adjusted.

Parkinson's disease: 1 tablet, 2 mg. three or four times daily.

Drug-induced extrapyramidal disorders: 1 tablet, 2 mg. one to three times daily.

How Supplied:

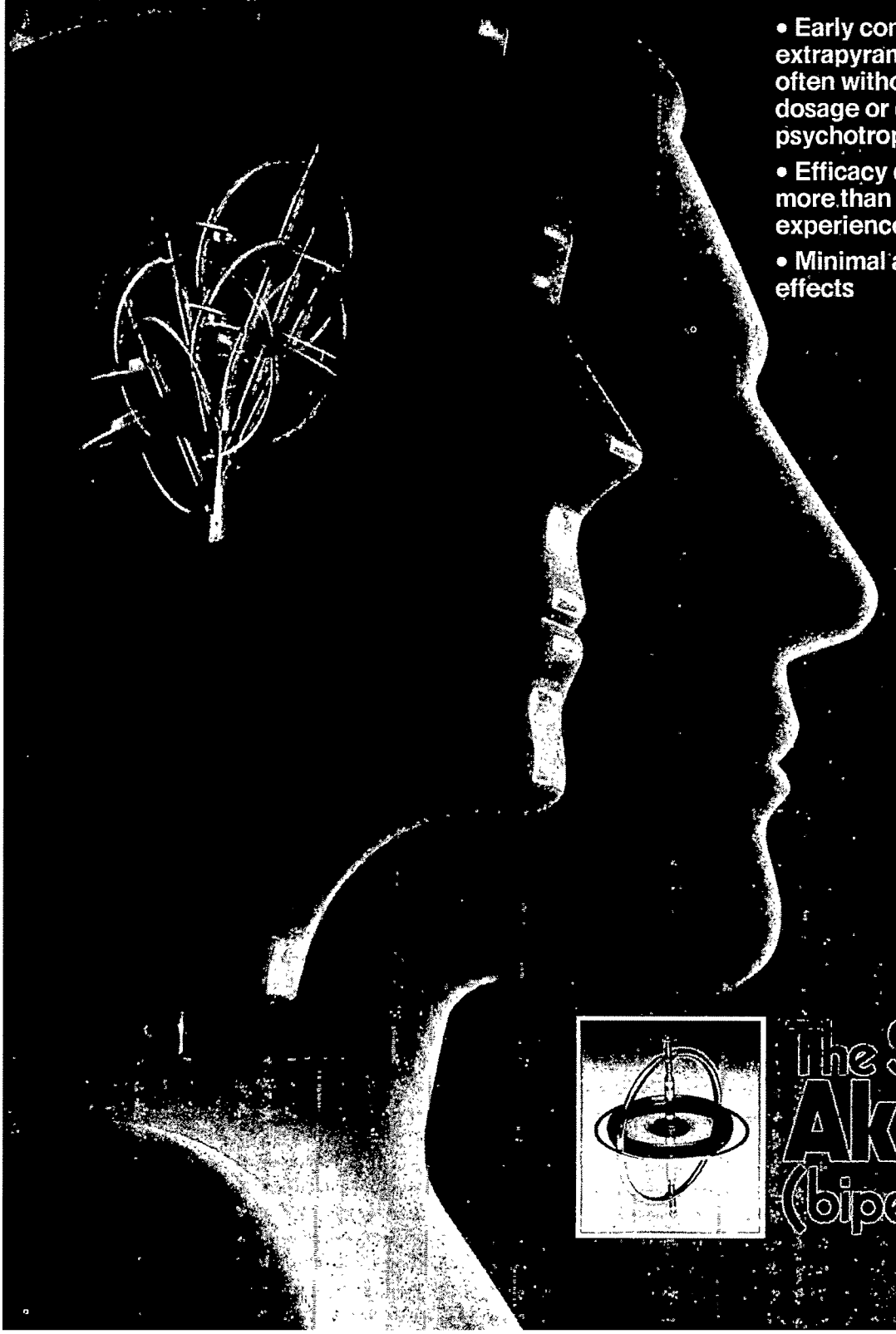
Akineton hydrochloride tablets, 2 mg. each, bisected—bottles of 100 and 1000.

Akineton lactate ampules, 1 ml. each containing 5 mg./ml. in an aqueous 1.4 percent sodium lactate solution. No added preservative. Boxes of 10.

Additional literature available upon request.

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EXTRAPYRAMIDAL REACTIONS



- Early control of drug-induced extrapyramidal reactions often without reduction in dosage or discontinuance of the psychotropic agent
- Efficacy demonstrated in more than a decade of clinical experience
- Minimal anticholinergic side effects

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(biperiden)

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In clinically significant depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD)

helps establish early therapeutic rapport

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of other tricyclic antidepressant poisoning.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

May enhance other remedial efforts in treating MBD[1]

ONLY WHEN MEDICATION IS INDICATED

Ritalin®
(methylphenidate)



Ritalin...of proven value when used as part of a complete therapeutic and remedial MBD program

More than a decade of clinical experience shows that Ritalin helps improve ratings of behavior, attentiveness, performance IQ, motor control, and speech productivity in children with Minimal Brain Dysfunction (MBD).[1-5]

Currently a drug of choice in many MBD situations,[6] Ritalin can play an important part in the total rehabilitation program of the MBD child. And proper management is essential to the overall (educational, social, and emotional) development of the child's potential.

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. Often, these interruptions reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and eventual discontinuance of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.



References
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3. Creager RO, VanRiper C: *J Speech Hear Res* **10**:623-628, 1967.
4. Werry JS: Paper presented at the Annual Meeting of the American Psychiatric Association, Boston, May 13-17, 1968.
5. Conners CK: *Pediatrics* **49**:702-708, 1972.
6. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)
TABLETS

INDICATION
Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)
Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.
Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.
CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.
WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC, differential, and platelet counts are advised during prolonged therapy.
ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.
DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.
HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

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Division of CIBA-GEIGY Corporation
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Ritalin® (methylphenidate)

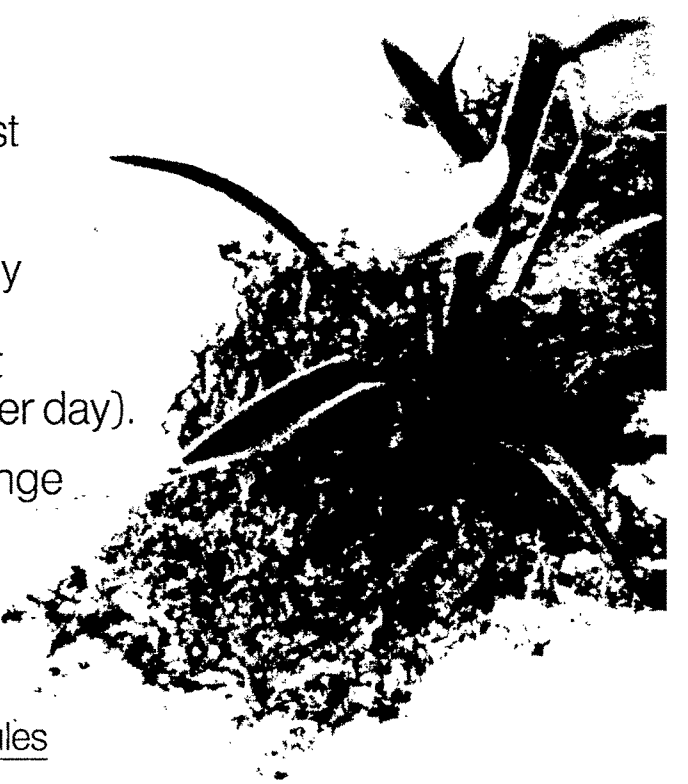
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DOXEPIN HCl

25-mg., 50-mg. and new 100-mg. capsules

(See Brief Summary on following page for information on adverse reactions, contraindications, warnings and precautions.)

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A CHANGE FOR THE BETTER IN CLINICAL DEPRESSION



SINEQUAN®
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BRIEF SUMMARY
Sinequan® (doxepin HCl) Capsules

Contraindications. Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects*: Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's).

More detailed professional information available on request.

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Several studies have reported the special effectiveness of HALDOL (haloperidol) in controlling disruptive and dangerously assaultive behavior.[1-3] Even the number of violent assaults committed by a group of criminal psychotics "resistant to maximal doses of phenothiazines" was reduced substantially during treatment with HALDOL.[1] Symptom control can be achieved rapidly, frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[2-4]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics the investigator states, "The patients remained alert and more amenable to psychotherapeutic intervention."[1] Another investigator reports that HALDOL "normalizes" behavior and produces a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[5]

Reduces risk of serious adverse reactions

HALDOL (haloperidol), a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. Hypotension is rare and severe orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, ocular changes, serious hematologic reactions and skin rashes.

The most frequent side effects of HALDOL (haloperidol)—extrapyramidal symptoms—are usually dose-related and readily controlled.

References: 1. Darling, H.F.: Dis. Nerv. Syst. 32:31 (Jan.) 1971. 2. Man, P.L., and Chen, C.H.: Psychosomatics *14*:59 (Jan.-Feb.) 1973. 3. Palestine, M.L., and Alatorre, E.: Paper presented Amer. Ass. Family Practitioners Annual Meeting, N.Y., Sept. 25-28, 1972. 4. Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. 5. Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965.

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

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Summary of Directions for Use

Indications: HALDOL (haloperidol) is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 6/74

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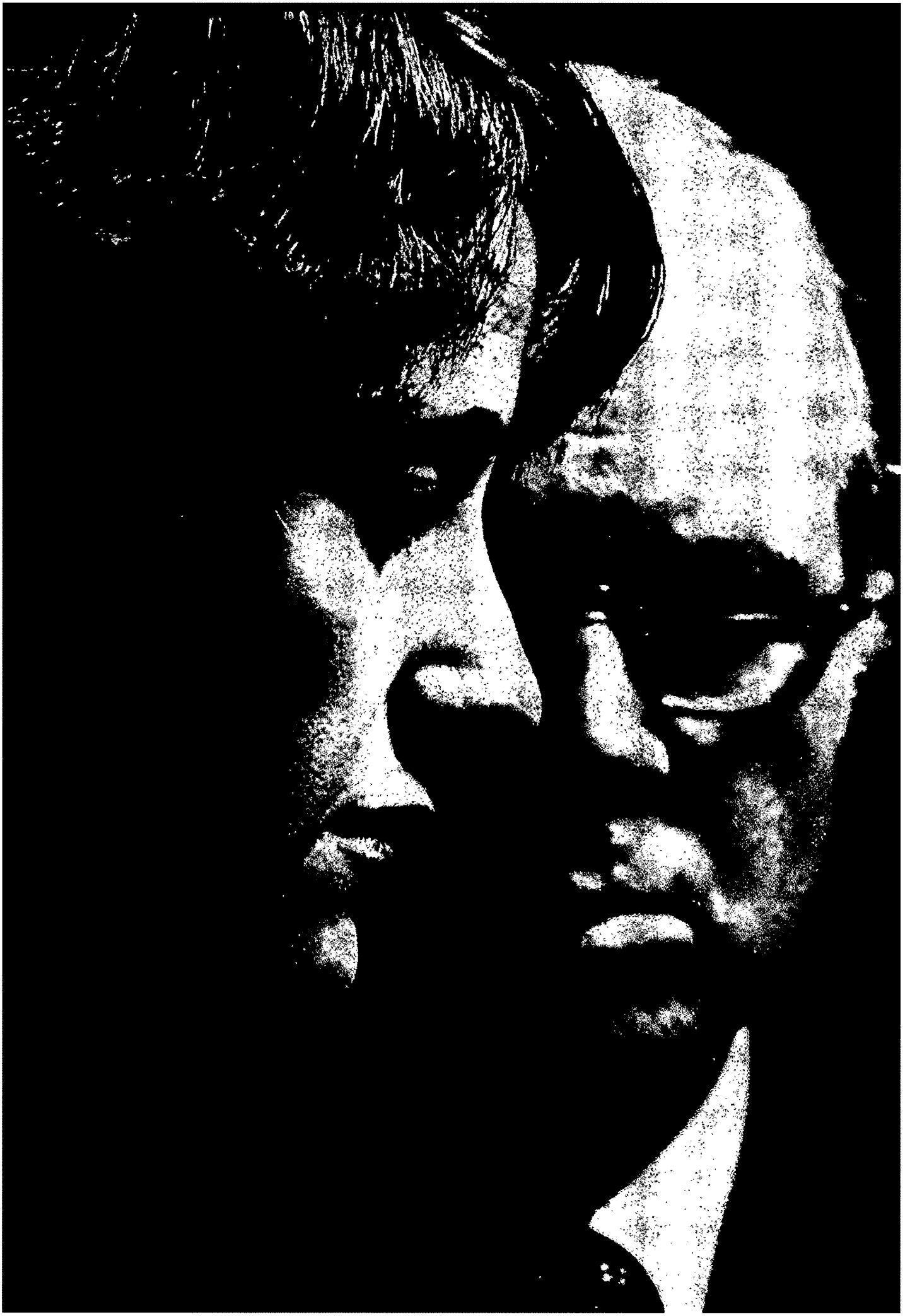
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Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

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CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastic distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information.
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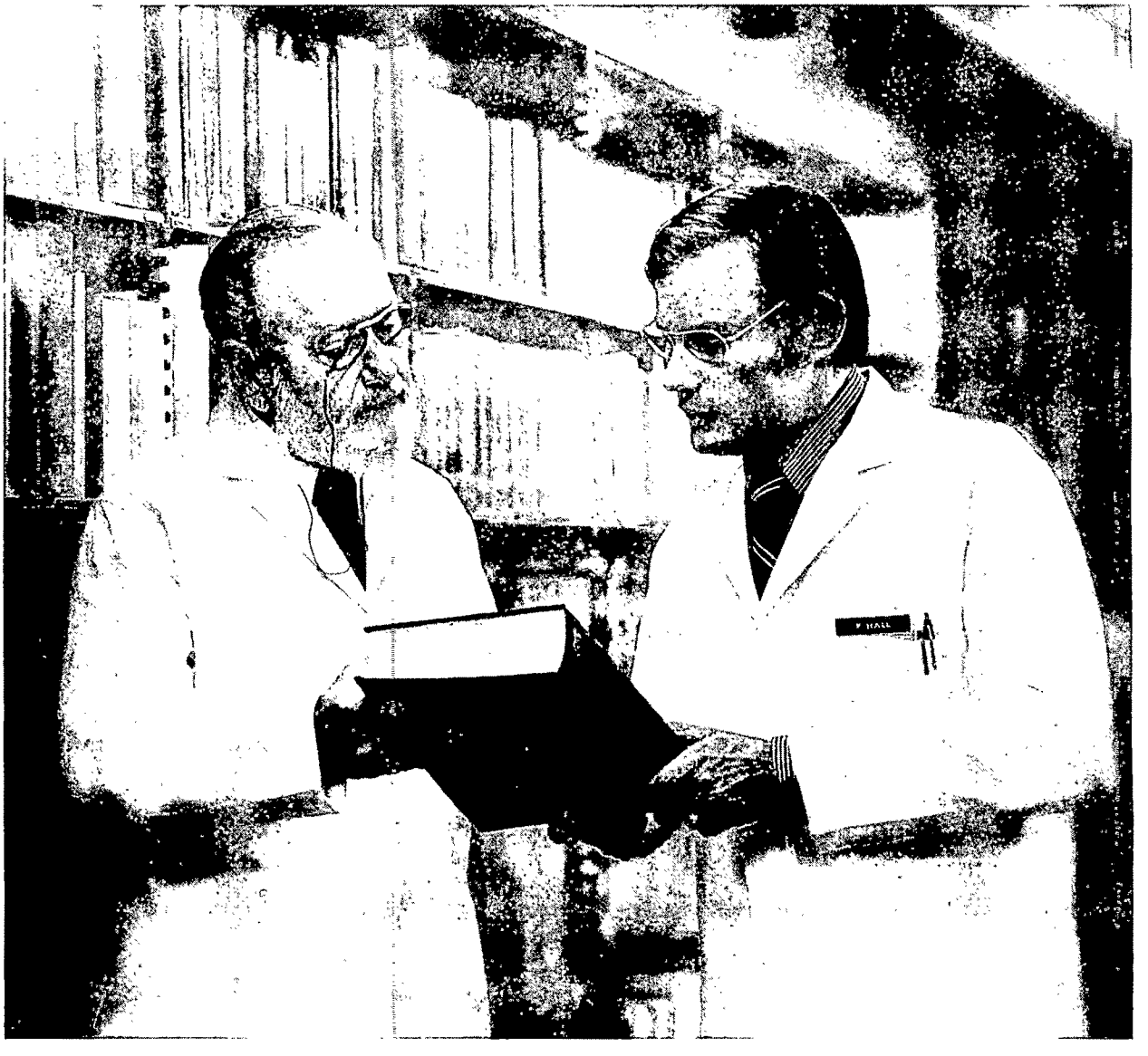
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Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

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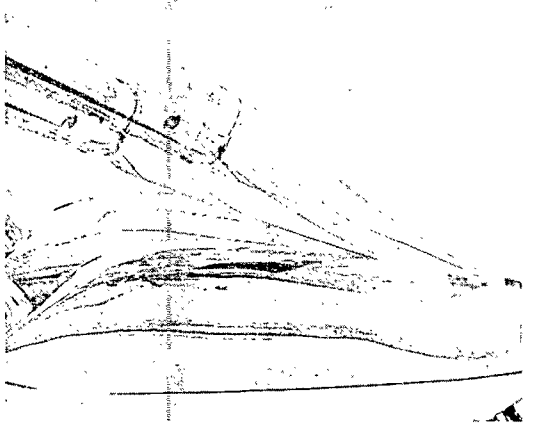
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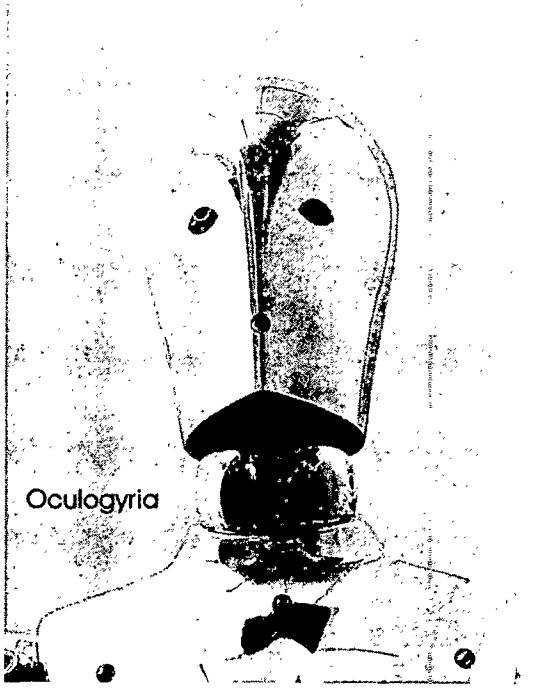
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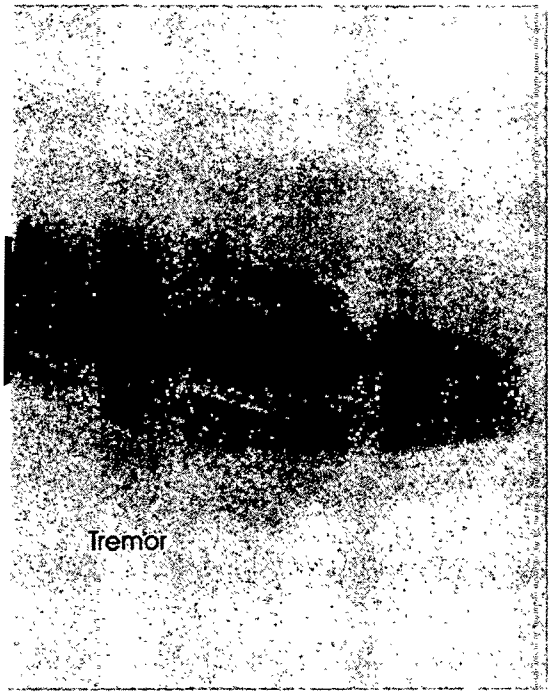
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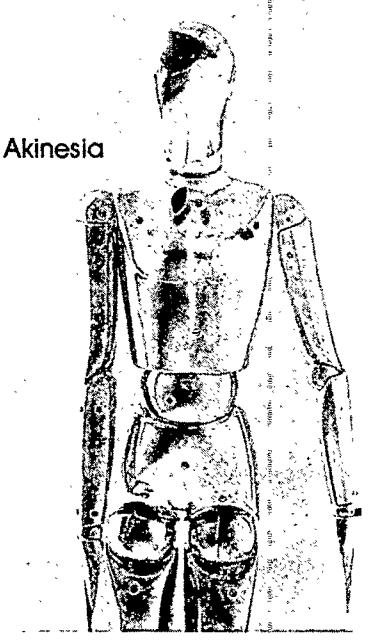
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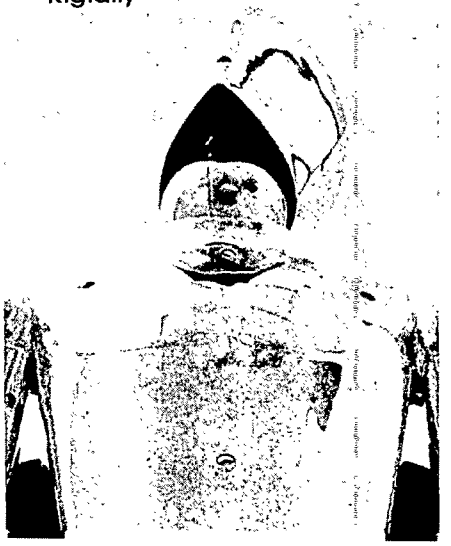


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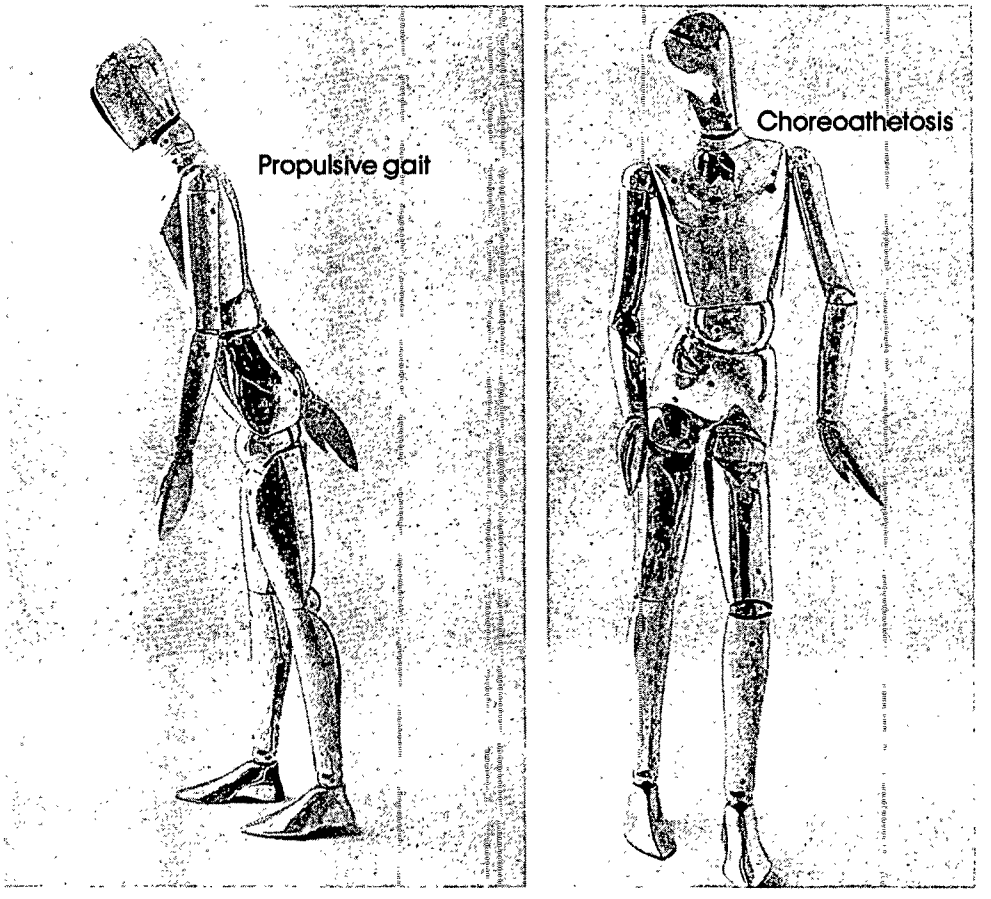
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Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated. Periodic gonioscopic evaluations in all patients to be treated with this or any related drug is advised.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilatation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache. Angle-closure glaucoma due to long-term treatment with this drug has been reported.

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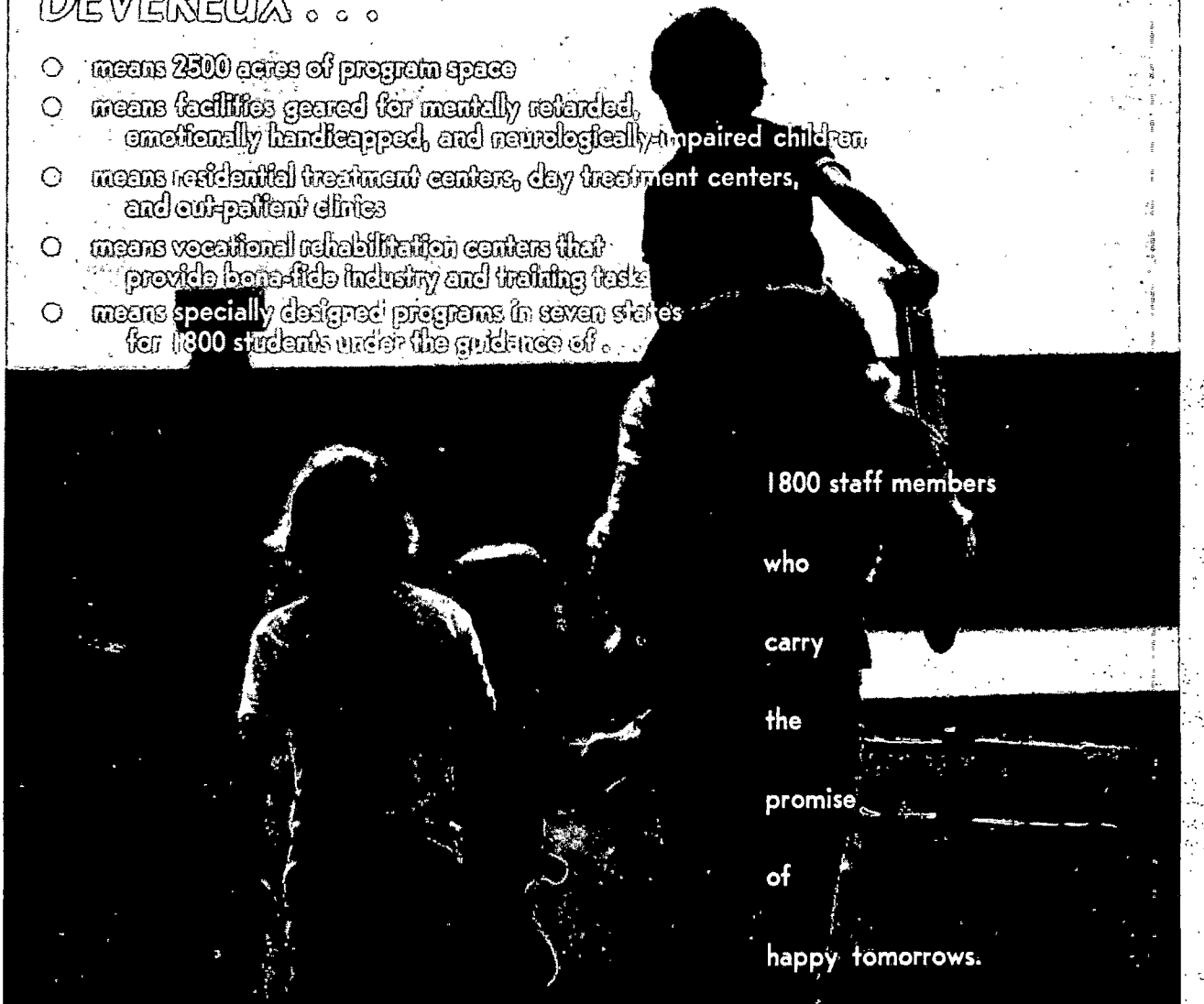
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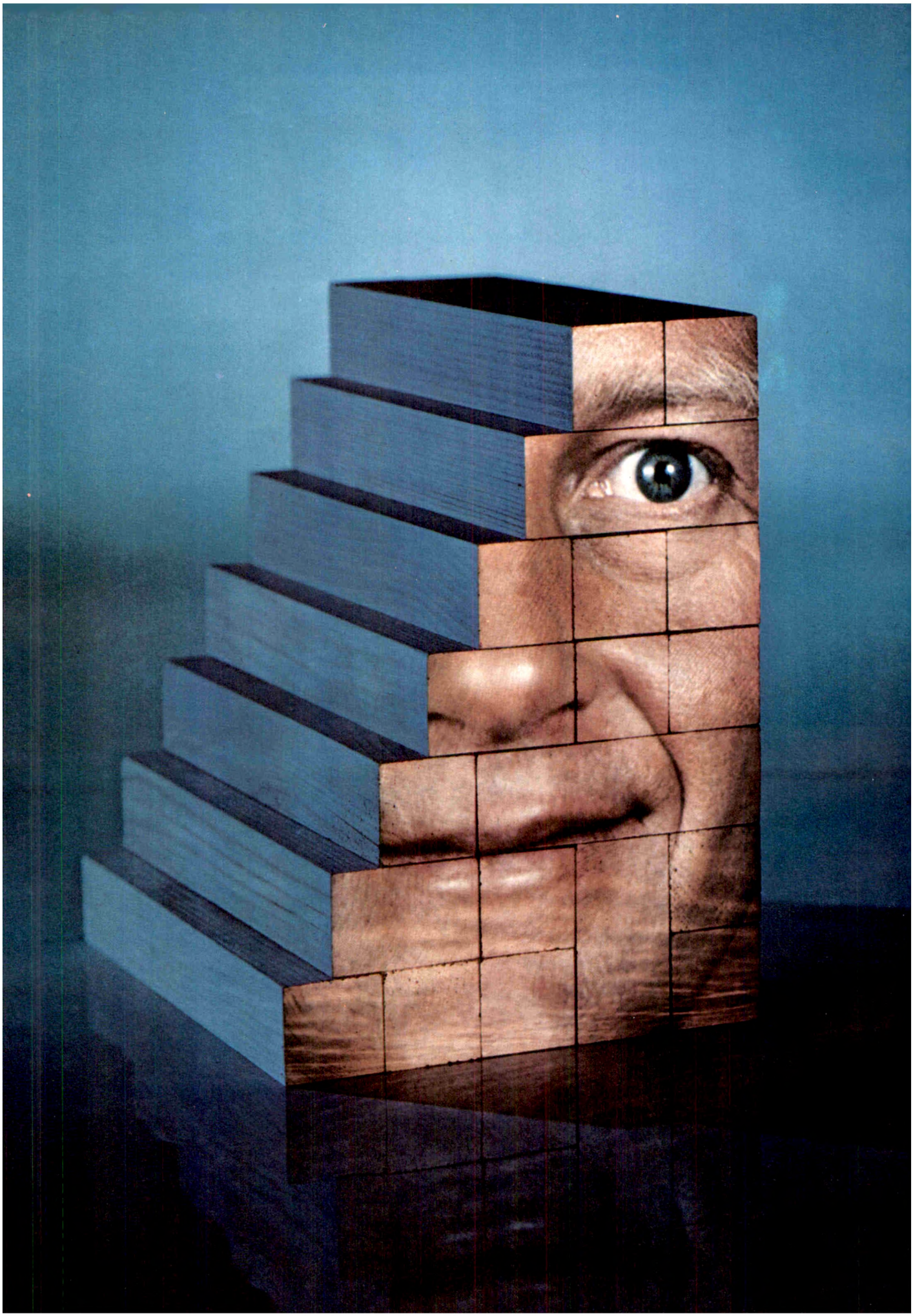
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In this issue

Psychiatry in China
by
Philip D. Walls,
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Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol.

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May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudo-parkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema.

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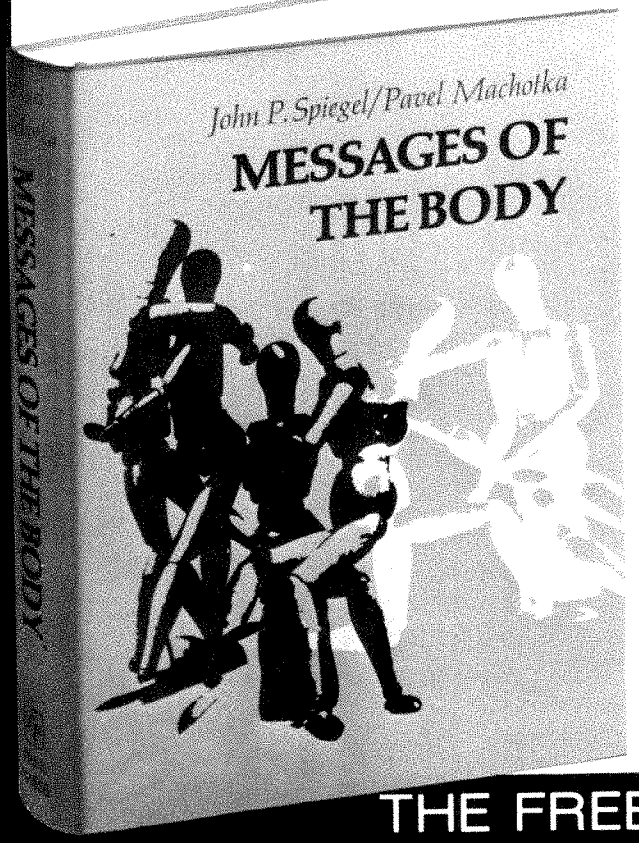
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Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

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1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

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imipramine pamoate

Capsules* of 150, 125, 100 and 75 mg.

One capsule lasts from bedtime to bedtime.

For single-dose therapy in depression when the dosage is established.

- simple enough dosage regimen to help avoid missed doses.
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- becomes part of the regular bedtime routine—making it easier to establish a more reliable pattern of self-medication.
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Please read the prescribing information for details of usage, precautions, warnings, contraindications, adverse experiences, and dosage recommendations. A summary of this information appears on the following page.

*Each capsule contains imipramine pamoate equivalent to 150, 125, 100 or 75 mg. of imipramine hydrochloride.

Tofranil-PM® Geigy
imipramine pamoate

One capsule lasts from bedtime to bedtime.

Tofranil-PM®
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Tofranil®
brand of imipramine hydrochloride USP

Indications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil, brand of imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

- —patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- —patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- —hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- —patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- —patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, Tofranil, brand of imipramine hydrochloride, is not recommended for treatment of depression in patients under twelve years of age.

Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil, brand of imipramine hydrochloride, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil, brand of imipramine hydrochloride, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. Dosage should be initiated with Tofranil, brand of imipramine hydrochloride, at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission.

Once-a-day maintenance dosage can be provided with Tofranil-PM, brand of imipramine pamoate, capsules if this dosage has been established as explained above. This dose may be given at bedtime. For the occasional patient who manifests stimulation and insomnia with this dosage regimen, the capsules may be given in the morning.

Parenteral administration should be used only for starting therapy in patients unable or unwilling to use oral medication. The oral form should supplant the injectable as soon as possible.

How Supplied: Tofranil, brand of imipramine hydrochloride: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg.; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-850-P (2/74)

For complete details, including dosage and administration, please refer to the full prescribing information.

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The Princeton Center for Behavorial Consultation will sponsor this program in:

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For infomation on these workshops, please write to: Ms. Debora Phillips, Princeton Center for Behavioral Consultation, Room 202, 53 Wilton Street, Princeton, NJ 08540

The March 1975 issue of

The American Journal of Psychiatry

will feature

- The 1975 Annual Meeting
  Preliminary Program

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In clinically significant depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of other tricyclic antidepressant poisoning.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

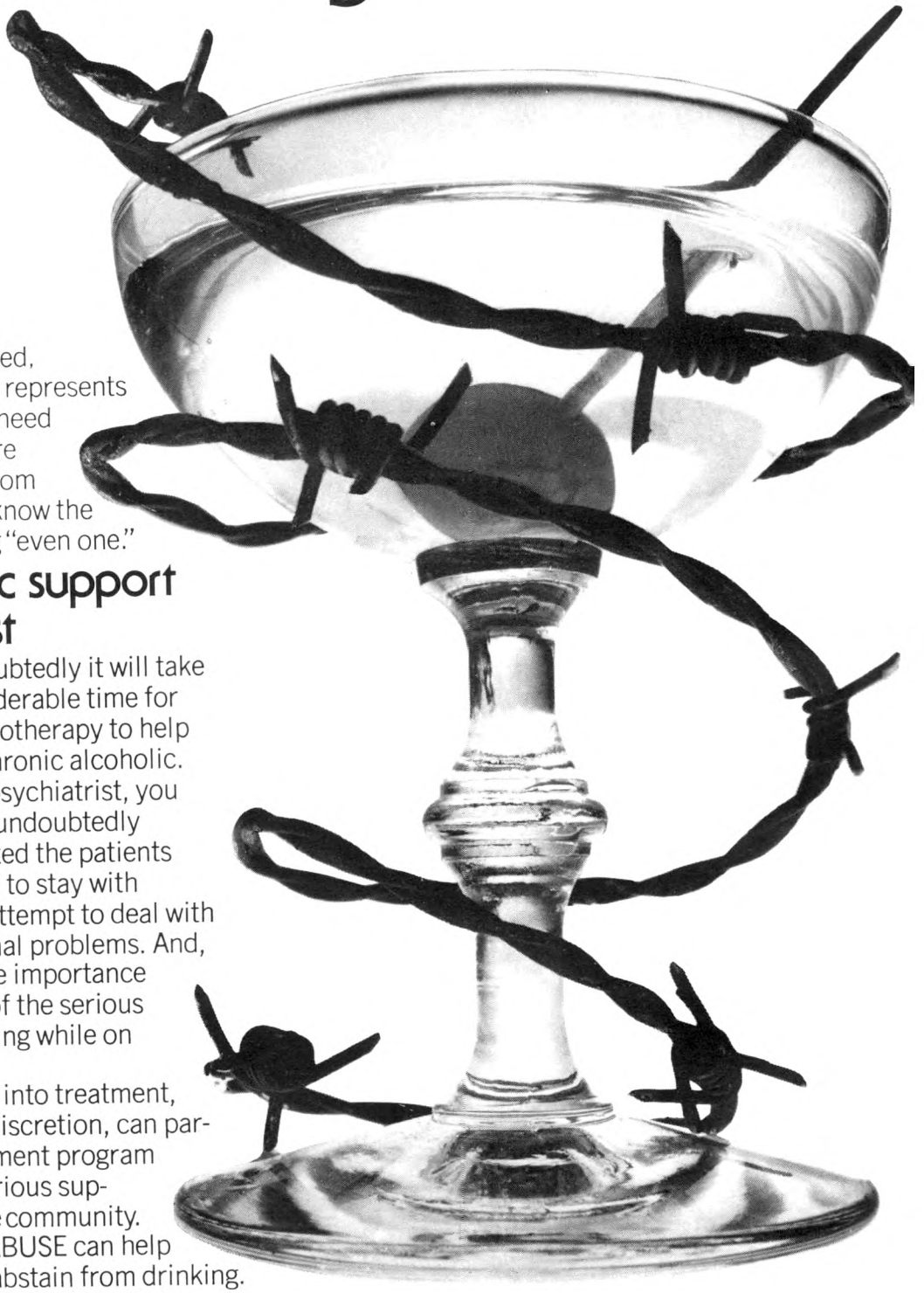
In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

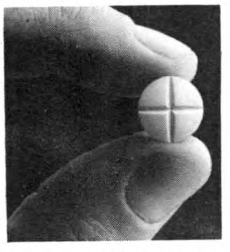
(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

ANTABUSE: "Social security" for the alcoholic who wants to stop drinking...



The temptation is resisted, ANTABUSE (disulfiram) represents the security alcoholics need in any situation. They are better able to abstain from drinking because they know the consequences of taking "even one."

until psychiatric support can do the rest



Undoubtedly it will take considerable time for psychotherapy to help the chronic alcoholic. As a psychiatrist, you have undoubtedly selected the patients who are best motivated to stay with ANTABUSE while you attempt to deal with the underlying emotional problems. And, of course, you know the importance of reminding patients of the serious consequences of drinking while on ANTABUSE.

Once sober, and well into treatment, the alcoholic, at your discretion, can participate in a total treatment program which makes use of various supportive resources in the community. In the meantime, ANTABUSE can help the chronic alcoholic abstain from drinking.

BRIEF SUMMARY
(For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) in Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g. cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE (disulfiram) should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE (disulfiram), report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

Ayerst.

7461

ANTABUSE®

BRAND OF DISULFIRAM


May enhance other remedial efforts in treating MBD[1]
ONLY WHEN MEDICATION IS INDICATED
Ritalin®
(methylphenidate)

Ritalin...of proven value when used as part of a complete therapeutic and remedial MBD program

More than a decade of clinical experience shows that Ritalin helps improve ratings of behavior, attentiveness, performance IQ, motor control, and speech productivity in children with Minimal Brain Dysfunction (MBD).[1-5]

Currently a drug of choice in many MBD situations,[6] Ritalin can play an important part in the total rehabilitation program of the MBD child. And proper management is essential to the overall (educational, social, and emotional) development of the child's potential.

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. Often, these interruptions reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and eventual discontinuance of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.



References
1. Knobel M: *Arch Gen Psychiatry* **6**:198-202, 1962.
2. Knights RM, Hinton GG: *J Nerv Ment Dis* **148**:643-653, 1969.
3. Creager RO, VanRiper C: *J Speech Hear Res* **10**:623-628, 1967.
4. Werry JS: Paper presented at the Annual Meeting of the American Psychiatric Association, Boston, May 13-17, 1968.
5. Conners CK: *Pediatrics* **49**:702-708, 1972.
6. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.

Ritalin® hydrochloride ℗
(methylphenidate hydrochloride)
TABLETS

INDICATION
Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)
Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.
Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.
CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.
WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC, differential, and platelet counts are advised during prolonged therapy.
ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy.
Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.
DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.
HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4854 17

Ritalin®(methylphenidate)

ONLY WHEN MEDICATION IS INDICATED

CIBA

Agitated and hyperactive?



Consider the advantages of starting him on HALDOL® (haloperidol)

Acts promptly to control agitation

HALDOL haloperidol appears to be particularly effective in calming mania and psychomotor agitation.[1-7] Symptom control is achieved rapidly, with many patients showing distinct improvement in a few days to a week[4,5]—frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[1,6,7]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL haloperidol is rare. In fact, this drug has been reported to increase activity in some underactive patients, while in hyperactive patients it usually reduces activity to a normal level without somnolence. HALDOL haloperidol has been found to "normalize" behavior and produce a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[8]

Reduces likelihood of certain adverse reactions

HALDOL haloperidol, a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. The most commonly noted side effects of HALDOL haloperidol—extrapyramidal reactions—are usually dose-related and readily controlled with antiparkinson drugs.

Transient hypotension occurs rarely; severe orthostatic hypotension has not been reported. HALDOL haloperidol is also unlikely to cause hepatic damage, serious hematologic reactions, photosensitivity reactions and skin rashes. Ocular damage and pigmentation changes have not been reported.

References: 1. Palestine, M.L., and Alatorre, E.: Quart. J. Stud. Alcohol 34:185 (Mar.) 1973. 2. Rees, L., and Davies, B.: Int. J. Neuropsychiat. 1:263 (June) 1965. 3. Sugerman, A.A., et al.: Amer. J. Psychiat. 120:1190 (June) 1964. 4. Rapp, M.S.: Canad. Psychiat. Ass. J. 15:73 (Feb.) 1970. 5. Towler, M.L., and Wick, P.H.: Int. J. Neuropsychiat. 3: Suppl. 1,62 (Aug.) 1967. 6. Man, P.L., and Chen, C.H.: Psychosomatics 14:59 (Jan.-Feb.) 1973. 7. Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. 8. Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965.

HALDOL®
(haloperidol)
tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

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HALDOL®
(haloperidol)
tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

A Dosage Form for Every Need:



5 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg., 5 mg. and 10 mg.



An undetectable, tasteless liquid concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.



A rapid-acting injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Indications: HALDOL haloperidol is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome.

Contraindications: HALDOL haloperidol is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL haloperidol in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of haloperidol orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL haloperidol, decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL haloperidol may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL haloperidol should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL haloperidol may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant antiparkinson medication is required, it may have to be continued after HALDOL haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson agents, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of antiparkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long-term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed. 9/74

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The "week-at-a-glance" Desk Appointment Book and the Pocket-sized version, published by the American Psychiatric Association, provide a quick and organized reference to your weekly engagements. As an added feature, it contains a comprehensive list of organizations and agencies of interest to psychiatrists and mental health professionals—in most cases director's name, address, phone number and date of forthcoming annual meeting are included. Also, there's a section to keep important phone numbers.

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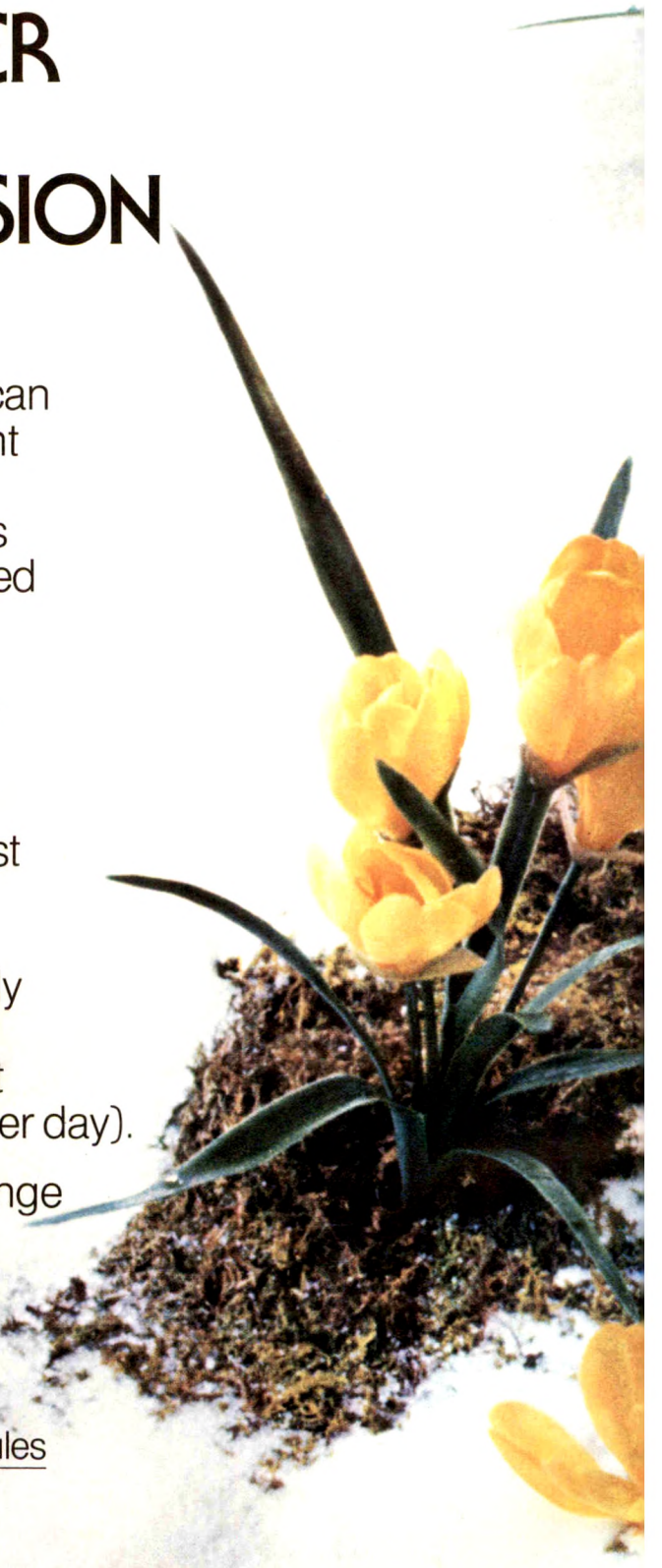
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(See Brief Summary on following page for information on adverse reactions, contraindications, warnings and precautions.)

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A CHANGE FOR THE BETTER IN CLINICAL DEPRESSION



SINEQUAN®
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25-mg., 50-mg. and new 100-mg. capsules

BRIEF SUMMARY
Sinequan® (doxepin HCl) Capsules

Contraindications. Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestina reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's).

More detailed professional information available on request.

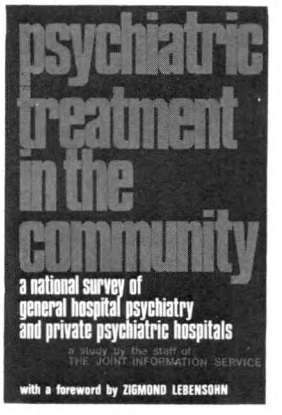
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In the psychiatrist's office. Whatever other therapeutic facilities have been developed, the psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations.

In the general hospital. The general hospital today usually provides a psychiatric unit where depressed patients may be treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic. With follow-up treatment often necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital. Here where severely depressed patients present challenges for psychiatrist and staff alike, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



In the community mental health center. A remarkable innovation in the field of modern psychiatry, this center offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

In many therapeutic settings—one proven antidepressant

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

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For a brief summary of prescribing information, please see following page.

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addendum

ELAVIL®
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25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

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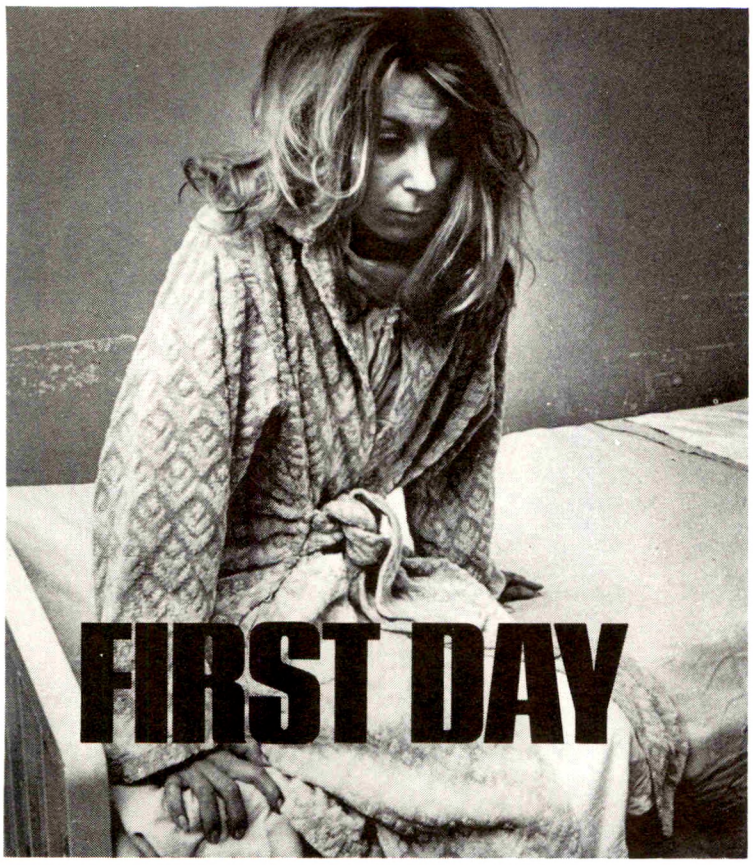
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With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

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helps in the management of psychotic patients with mixed anxiety-depression

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

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THE AMERICAN JOURNAL OF PSYCHIATRY

Psychiatric Training and Practice in the People's Republic of China

BY PHILIP D. WALLS, M.D., LICHUN HAN WALLS, PH.D., AND DONALD G. LANGSLEY, M.D.

Improved political relations between the United States and the People's Republic of China have led to closer contact in many areas. The authors trace the development of psychiatric training and practice in China with emphasis on the years after 1949. Since then, China has expanded psychiatric services to meet the needs of a vast population and has developed a theoretical approach to psychiatry that emphasizes sociopolitical factors. Additional information given to the authors in 1973 by psychiatrists in Nanking and Shanghai is presented and correlated with reports by other recent visitors to the People's Republic of China.

ALTHOUGH A NUMBER of American physicians have visited the People's Republic of China since 1972, when travel restrictions were relaxed, there are few firsthand reports about psychiatry and mental hospitals in China. Two of us (P.D. Walls and L.H. Walls) visited China from August 8 to October 21, 1973, to gather and exchange information about medical and psychiatric education and practice. L.H. Walls, a biochemist, is a native of China and is fluent in Mandarin Chinese, as well as being familiar with psychiatric terminology and practice in the United States by virtue of her marriage to a psychiatrist.

The itinerary included Canton, Shanghai, Hangchow, Nanking, and Peking and a visit to a medical school in each of these cities. We met with practicing psychiatrists in Nanking, and in Shanghai we were able to visit psychiatrists and to tour the Shanghai Psychiatric Institute. Visits to a commune near Shanghai and to one near Peking were also arranged, as were visits to various factories, hospitals, clinics, a nursery, a kindergarten, a youth recreation center, and many exhibitions and sights in these cities. All such arrangements were made in each city through local offices of the International Travel Agency of the People's Republic of China, whose agents were courteous and helpful in the handling of so many requests. Our trip was not sponsored by any groups inside or outside China.

We submitted requests in each city visited, and although it was not convenient for all of them to be granted, we received a great deal of cooperation and enjoyed considerable freedom. We were always permitted to take notes during interviews, and we routinely received permission to tape-record the interviews. The tapes were transcribed verbatim into English as soon as possible after each interview in order to avoid misquotations and imperfect recollection. We conducted interviews with groups rather than individuals. At a hospital the group might include an administrator (usually the chairman of the Revolutionary Committee of the hospital), several physicians, and nurses. After introductory remarks had been presented, there was a tour of the facilities and an exchange of questions and answers. The meetings usually lasted a whole morning or afternoon, but only one meeting could be arranged with any one group. This restriction must be due in part to the increasing numbers of visitors, who would consume too much of the working staffs' time if all received repeated appointments.

PSYCHIATRY IN TRADITIONAL MEDICINE

Mental illness has been recognized in China for over 2,000 years. Paralysis, epilepsy, and hysteria were mentioned in early texts and were described as maladies of "wind" (1). In China the concepts of "breath" and "wind" are still popularly believed to affect health. "Breath" is comparable to very early Greek and Roman notions of "psyche" (from the Greek *psychein*, to breathe, to blow) and of "spirit" (from the Latin *spirare*, to breathe). Specialization in psychiatry existed in the

At the time this work was done, Dr. Philip Walls was a resident in psychiatry, University of California, Davis School of Medicine, Sacramento, Calif.; and Dr. Lichun Walls was formerly Assistant Professor of Chemistry, California State University at Fresno, Calif. Dr. Philip Walls is currently Clinical Associate, National Institutes of Health, St. Elizabeths Hospital, Washington, D.C., and Dr. Lichun Walls is Assistant Professor of Chemistry, Morgan State College, Baltimore, Md. Dr. Langsley is Professor and Chairman, Department of Psychiatry, University of California, Davis School of Medicine. Address reprint requests to Dr. Philip Walls, 3605 Farness Dr., Temple Hills, Md. 20031.

11th century, when one Chinese medical school had established a separate department of nervous and mental disorders with 30 students.

In the first decade of the 17th century, observation and classification of mental disorders had progressed to the extent that a famous doctor of traditional Chinese medicine, Wang K'en-T'ang, wrote on insanity, mania, and fits (2). His description of insanity fits schizophrenia very well, and mania and grand mal seizures are also well characterized. Wang noted that the insane got no better even after years of illness. He believed that these patients had "wind in the mind," and he offered the explanation that "those with frustrated ambition are likely to be so affected." Chang Chieh-Pin, a contemporary of Wang's, pointed out that insanity resulted in progressive deterioration. Chang also alluded to the phenomenon of febrile delirium, and he commented on the lack of childhood cases of insanity (2). Acupuncture, herbal preparations, exercises of various kinds, and other traditional methods were used in the treatment of mental illness. However, little change in classification or treatment seemed to develop inside China after the 17th century.

Some of the reasons for this slow development of mental health sciences may be related to factors described by Ilza Veith (3). She suggested that the Chinese were traditionally less concerned about mental illness than the Europeans, although, as Bowman (4) has confirmed, mental illness was as common in China as in other countries. The tradition of respect for elders (filial piety) and the practice of using go-betweens in potentially embarrassing situations (part of the tradition of saving face) may have done much to lessen the impact and importance of mental disturbance in individual cases. Veith (3) also pointed out that in China mental illness was never associated with any religious stigma, such as that which stimulated much controversy and theoretical discussion in the West.

PSYCHIATRY IN MODERN TIMES (1900–1949)

Western psychiatric ideas were introduced in China about 75 years ago when the first Western-style mental hospital to receive patients was established in 1897 in Canton province. A course in psychiatry was taught at the Peking Union Medical College for the first time in 1922. The practice of psychiatry continued to make slow gains over the 50 years from the establishment of the first asylum for the insane to the inauguration of the People's Republic of China in 1949 (5). At that time only four psychiatric hospitals may have been in operation in all of China (5, 6), with a total capacity of 1,000 to less than 6,000 psychiatric beds and 50 to 60 practicing psychiatrists (4, 6). In regard to psychiatric theory, Cerny (6) has stated that "the teachings of Adolf Meyer were widely accepted in Chinese psychiatry" until 1949.

A report of a brief visit to Peking's An Ding mental hospital provides a glimpse of conditions during the pre-1949 period. This hospital, founded in 1917, was said to have been under police control and neglected for 30 years. There were allusions to experimentation on patients during those years. The hospital had 50 beds in 1949 and was until then being supervised by a non-psychiatric physician who worked only part-time (7).

PSYCHIATRY AFTER 1949

The facilities for psychiatric care and the number of psychiatrists in the People's Republic of China grew rapidly after 1949. The number of beds for psychiatric patients increased from approximately 1,000 to a total of 5,000 in 1955 (8) and 20,000 by 1957 (6). There do not seem to be any data on the number of psychiatric beds after 1957, but a reasonable estimate for the present number is about 60,000. Sixty new mental institutions had been built by 1959, and clinics had been set up in the cities (9). The People's Republic of China has 29 administrative districts at the provincial level on the mainland, and this means an average of about two mental hospitals per province. The municipalities and environs of Shanghai and Peking comprise two of these provinces. In 1957 Fox (10) reported that 600 psychiatric beds were needed for a medical complex in Shanghai; it appears that by 1966, two psychiatric hospitals with a total of 400 beds had been built (11). A recent study quoted a combined total figure of close to 2,000 beds for the two Shanghai hospitals (12). It has been reported that there were a total of 1,500 psychiatric beds in Peking in 1966 (7). An approximation of 2,000 beds per province suggests a figure of about 60,000 beds for the entire country, a number that can also be determined by alternative methods (see following paragraphs).

The meager number of psychiatrists in 1949 grew to 100 in 1952 and to 400 in 1957 (6). Lazure (13) was told in 1959 that there were 15 times the number of psychiatrists as in 1949, or about 900, judging from Cerny's quoted figure (6).

Although no official figures are reported for the number of psychiatrists after 1959, there are several ways to make a current estimate, and each one produces a similar total. One method takes note of the 61 psychiatrists in one of the two Shanghai mental hospitals. This figure was given to us during our visit and to three others (12, 14, 15). If the two Shanghai mental hospitals have similar staffs, there are about 120 practicing psychiatrists in that province and about 3,500 in all 29 provinces. Alternatively, 60 mental institutions were operating in 1959, and if these are now of comparable size to the present Shanghai units, then there are about 3,600 psychiatrists (60 hospitals times 60 psychiatrists is 3,600). Finally, an increase of about 40,000 Western-style physicians was reported in the People's Republic of China from 1949 to 1959 (13, 16, 17), of whom about 900 were psychiatrists, which is a ratio of approximately 1:50. If this ratio held for the next seven years, when 150,000 (18) to 180,000 (7) Western-style doctors were reported, this would suggest a figure of about 3,500 psychiatrists and about 60,000 psychiatric beds, extrapolating from the ratio of psychiatrists to beds in Shanghai.

Due to the reorganization of the Cultural Revolution

in China (1966–1970), few additional doctors have been trained since that time. The first classes of newly trained physicians graduated from some of the medical colleges in 1974 (19).

The 10 years after 1949 showed great growth and change in the mental health field in China. A Society of Neurology and Psychiatry was founded in 1952, and the *Chinese Neurological and Psychiatric Journal* was published from 1955 (6) until the Cultural Revolution. Williams commented that the psychiatrists with whom he spoke "were undoubtedly capable and extremely busy with treatment and teaching" and that "psychiatry is given a place in the medical curriculum quite as high as in most Australian universities" (8). Each of the 50 medical colleges operating in 1960 had departments of psychiatry (13).

A movement to humanize the mental hospitals took place in these early years, especially during the Great Leap Forward of 1958, when an attitude was developed that "humane considerations were to govern the handling of patients" (9). In 1957 chains, isolation, and psychosurgery had been prohibited in Shanghai (6). The use of chains and confinement was discontinued in Peking's An Ding Hospital in 1958 (7). Reviews and reports have provided little knowledge of the day-to-day interaction between doctors, nurses, and their patients. There does not seem to be any information on facilities for the mentally ill from 1959 to 1966 (9). In 1966, however, the physical structure of An Ding Hospital was described. "Not many frills were noted, but then there are very few frills in the Chinese life of today. There was evidence, however, of a good general attitude towards mental illness and there was a sound approach towards rehabilitation" (7, p. 352). There is no indication of whether patients in rural areas were managed similarly or differently from those in the cities.

Most patients classified as needing psychiatric care are referred to regional hospitals for treatment. Inpatient and outpatient care is available. The range of diagnoses given to hospitalized patients is similar to that in this country. From 60 to 80 percent of the patients in three separate reports were classified as schizophrenics (7, 12, 20). The remainder of diagnoses were divided among manic-depressive psychoses, organic brain syndromes, depression, and severe neuroses. The average length of hospital stay varied from three months (7) to 70 to 84 days (14, 21).

Psychiatric Treatment

Treatment for hospitalized patients covers a variety of Western and indigenous methods. For years, persistent efforts have been made to combine Western and Chinese modes of treatments in the field of mental health care as well as in other areas of medicine. Work therapy (6, 13), insulin coma therapy, ECT, sleep therapy, and tranquilizers, but not hypnotherapy or psychosurgery, were used through the early 1960s (6). Chlorpromazine was the principal medication for schizophrenia at An Ding Hospital in Peking in 1966, and depressed patients usually received insulin coma or subcoma therapy. Imipramine had been used previously, but "there had been no great demand" for antidepressants at that time (7). A report of the treatment of mental illness at the Third Peking Hospital in 1972 indicated that schizophrenia was managed with "customary drug therapy" (usually chlorpromazine) and insulin coma therapy and that depression was treated with antidepressant medication (20). Moreover, psychiatrists in Nanking told us that "insulin shock and ECT are used in schizophrenia, insulin more than ECT, if regular measures fail in a given case. It is not used in depression since cases get better with drugs as a rule." According to two reports, insulin coma therapy and ECT have not been used in at least one Shanghai mental hospital since 1970 (12, 15), although this may not yet be the case in general. Currently, the usual treatment for depression seems to be antidepressant medications. Lithium carbonate is used in the treatment of mania (12).

Taipale and Taipale (12) and Ratnavale (14) reported that the maximum daily dosages of chlorpromazine in the treatment of schizophrenia were 200 mg and 250 mg, respectively. We were told that the maximum daily in-hospital dosage was about 600 mg at the Shanghai Psychiatric Institute. The tendency to use increasing doses of phenothiazines in the treatment of schizophrenia seems to have occurred in China as it has in the West.

In addition to drug therapy for mental patients, the Chinese use acupuncture, group therapy in political study groups, counseling by other patients, and appropriate job modification after discharge (22). Psychotherapy is described in various sources. The Chinese literature increasingly discussed "psychogenic factors" in the etiology of mental illness between 1956 and 1966, when Pavlovian psychology was influential in placing emphasis on psychotherapy (9). Heart-to-heart talks between patients and nurses and doctors have become a prominent part of the treatment process (12, 14, 15).

A major therapeutic device is to help patients merge their egos with the collective ego of the state. Patients are presented with the concept of nationalism (22), consisting of exhortation for increased devotion to the community and the state, as a stimulus to generate inner strength with which to overcome mental illness. Point-by-point confrontation of delusional ideas is another part of the interaction between therapists, group members, and the patient (23). Patients may return to the hospital to talk with their nurse (12), or a doctor or nurse may make home visits (22). Group discussions of political works, such as Mao's writings, are held regularly in the hospital with doctors and nurses. Work group discussions of politics are also a regular feature of life for every Chinese citizen, and the use of this mechanism in the hospital is not a novelty.

Sidel visited the "Shanghai Mental Hospital" in 1971 and 1972 (15, 21, 22); Taipale and Taipale visited the "Central Mental Hospital" of Shanghai in 1972 (12); and Ratnavale visited the "Shanghai Psychiatric Institute" in early 1973 (14). Our guide used the name "Shanghai Psychiatric Institute" during our visit, but a more literal translation would be "Shanghai Municipal Psychiatric

Preventive and Treatment Center." A close comparison of the information reported by the four groups showed that all visited the same hospital. This confusion in names is an excellent example of the potential difficulties involved in the translation of even simple matters from Chinese to English. (We will use the name "Shanghai Psychiatric Institute" in further references to this hospital.) Visitors have reported that the institute has 61 psychiatrists on its staff (12, 14, 15), 916 beds (12, 15), and 13 wards (14, 15). We were told that it had 14 wards, 974 beds, and a total staff of 583, including 61 doctors and 213 nurses. This appears to mark an increase in the overall size of the hospital since previous visits.

Little is known about the psychiatric treatment used in outpatient clinics. Cerny (6) reported that acupuncture and other traditional techniques (herbs, exercises, and moxabustion, which is the application of heat to acupuncture points), as well as psychotherapy and pharmacotherapy are used in the treatment of neurotics. Sidel mentioned that chlordiazepoxide, diazepam, acupuncture, herbs, lectures, and individual and group therapy are given to neurotic outpatients (22). Ratnavale wrote that most of the 400 outpatients seen daily at the Shanghai Psychiatric Institute suffered from neurotic and psychosomatic conditions (14), but this contrasts with information from our visit. An introductory speech at the Shanghai Psychiatric Institute included the comment, "Most of the outpatients are those who have received inpatient treatment here. In some cases the outpatients suffer from neurasthenia or epilepsy." However, in still another reference, Chin and Chin reported that 60 percent of the patients treated in the Peking Medical College outpatient mental health department in 1959 were neurasthenics (9). They also pointed out that no statistics are available on the incidence of neurotic illness in the People's Republic of China. Paul T.K. Lin, in a paper presented at the 1973 annual meeting of the American Psychiatric Association, commented that neuroses are practically nonexistent in China (24).

Psychiatric Theory

The theory of mental illness in the People's Republic of China appears to be no less controversial than the statistics, although of course this statement is equally true of Western schools. Pavlovian psychology was a powerful influence up to and probably beyond the Sino-Soviet rift, which took place in 1960. On the one hand, the biological determinants of mental disorder may be stressed in theory and practice, and on the other hand, sociopolitical factors may take the limelight. At different times and in different places, one or the other orientation has been given emphasis. Chin and Chin have outlined the development and progress of this controversy up to 1966 in their excellent book (9).

The controversy continues to the present. In reply to our questions about the etiology of schizophrenia, Nanking psychiatrists cited their belief in genetic and organic origins. Kagan's report from Tientsin (23) seems to show a bias toward social factors there, although the point that biological and social factors are not mutually exclusive is also made. In Shanghai a middle ground seems to be taken. Most patients appeared to be receiving one or more medications or somatic treatments, and all but the most agitated and disorganized patients joined in group therapy. Works of Mao, Marx, and Lenin and current affairs were common topics of conversation. When we asked whether discussions with patients regarding their illness centered around the content of their thinking, the reply was,

> If some patients suffer from delusion, we hold that it may be due to a confusion of the logic in their minds. Therefore, we try to educate them to think in a correct way. We arm their minds with Marxist-Leninist philosophical thinking. Chairman Mao's philosophical works will be assigned for them to read in order to let them know where the correct thinking comes from. So we do not give the patients any sex analysis or psychoanalysis.

All of the foregoing is consistent with the Pavlovian notion of "correct" thought leading to "correct" processing by the mind's second signal system, which in turn leads to "correct" behavior. It is basic in the thinking of the new China that change and improvement are almost always possible, given enough effort and the right kind of mutual help. Freud's concept of the unconscious, a part of the mind hidden from and inaccessible to direct confrontation and change but still able to influence behavior, is not compatible with the Chinese view. Moreover, Freudian psychology is seen as based on Western idealism, a philosophy with which the dialectical materialism of Communism is in opposition. Freud emphasized the individual, the self, and this finds little harmony in the Chinese state, which emphasizes the group, the nation, and the family. A thorough understanding of Freudian psychology requires years of study and practice, tending to create an elite group of doctors, and elite groups are anathema in the People's Republic. Finally, the subject of sexual drive is simply not felt to be important in the etiology of mental illness.

It is important that Freudian-trained readers consider these differences in opinion and interpretation when trying to follow the Chinese points of view and practice. They explain the laughter that followed the Sidels' question about Freud's influence in Chinese psychiatry (21). When we asked if Chinese psychiatrists believed in the developmental theory of mental illness, our Nanking hosts said flatly that they did not. "Under Chairman Mao's guidance, after Liberation [1949], everyone believes in dialectical materialism and everyone is happy. There is no conflict for the children." In response to the same question, Shanghai psychiatrists answered,

> We have not yet arrived at a unified explanation as to the causes of [mental] disease. Some people hold that the role is played by chemical changes in the brain or genetic factors. We think that a reasonable social system will reduce the environmental causes of mental diseases. But will it also be effective in reducing the occurrence of schizophrenia? Well, there are still some disputes.

One 1957 statistic cited for the prevalence of schizophrenia in the People's Republic puts it at one-tenth of Western countries (12).

The place that neurosis currently holds in Chinese psychiatric theory is especially hard for Western observers to discern, for although Freudian views are rejected, some similar terms with perhaps different connotations are maintained. Diagnoses of neurotic patients include such terms as neurasthenia, hysteria, phobia, and obsessive-compulsive neurosis. The most prevalent diagnosis is neurasthenia, a nonspecific term without an English equivalent. Common symptoms of neurasthenia are insomnia, headache, dreams, and pains (9). It is difficult to find detailed descriptions of the other diagnostic categories as the Chinese use them.

PSYCHIATRY IN NANKING AND SHANGHAI

Diagnosis

Our interviews with psychiatrists in Nanking and Shanghai confirmed much of the material already discussed and added some new information. In Nanking, hospitalized patients were classified as having schizophrenia, manic-depressive psychosis, involutional psychosis, organic psychosis, symptomatic psychosis (after Mayer-Gross, Slater, and Roth's definition [25], which includes various organic diseases that present with psychosis), and psychogenic psychosis, which includes hysterical psychosis and depression. Diagnostic categories for nonpsychotic disorders included neurasthenia, obsessive-compulsive neurosis, hysteria, and phobia. No detailed statistics were available for the frequency of these diagnoses in the neuropsychiatric hospital in Nanking, but schizophrenia was diagnosed in more than 50 percent of the patients. In Shanghai, additional diagnostic classifications of hospitalized patients included postpartum psychosis, encephalitis, senile psychosis, cerebral atherosclerosis, and mental disturbances secondary to stroke. According to psychiatrists with whom we spoke, about 60 percent of the patients at the Shanghai Psychiatric Institute are diagnosed as schizophrenic, with the remaining 40 percent given various other diagnoses.

No classification for childhood mental illness was given in Nanking, but one 10-year-old girl with "childhood schizophrenia" was seen at the Shanghai Psychiatric Institute. The only child in the hospital at the time, she was being treated on a ward for women. There has been a general lack of demand for psychiatric facilities for children in China, and there does not appear to be a subspecialty of child psychiatry. A unit for the treatment of children under 13 or 14 years of age was in operation at the Shanghai Psychiatric Institute prior to 1966, but it was closed after the Cultural Revolution because it was relatively unused. One or two of the hospital psychiatrists with the most experience in treating children were called upon when the need arose.

Personality disorder was recognized as a diagnostic entity, but the cases were said to be few and the patients were not usually treated in a mental hospital. In Shanghai this was felt to be a job for "reeducation" and was done at some other, unspecified, place. Personality disorder accompanying schizophrenia or epilepsy was treated by the hospital staff. A nonpsychiatric physician commented that in the early years after 1949, sedatives and "some treatment" of an undefined sort were given to homosexuals who suffered from anxiety, but that not many such patients had been seen in recent years. One reason suggested for this decline was that it might be due to the change in the social system and the radical change in the moral standards of the society.

Treatment

The average length of stay at the neuropsychiatric hospital in Nanking was three to four months. The figure given at the Shanghai Psychiatric Institute was 70 days, the same as quoted in earlier reports (14, 21).

Schizophrenia was treated with drugs, herbs, electroacupuncture, and regular acupuncture in both cities. The use of ECT and insulin coma therapy in Nanking has already been described, along with the use of medications for depression. Insulin coma therapy and ECT have not been used at the Shanghai Psychiatric Institute since 1970. The combined use of Chinese and Western modes of therapy was emphasized. Psychiatrists had the clinical impression that the dosage of Western drugs needed to bring about recovery was reduced by half when acupuncture and/or herbs were used concurrently.

Maximum dosages of medications for hospitalized patients in Nanking were as follows: chlorpromazine, 450 mg a day; trifluoperazine, 20 to 30 mg a day; perphenazine, 30 mg a day; and chlorprothixene, 450 mg a day. The following were the maximum daily dosages given to outpatients: chlorpromazine, 100 to 150 mg a day; trifluoperazine, 10 mg a day; perphenazine, 6 to 10 mg a day; and chlorprothixene, 100 to 150 mg a day. Imipramine for depressed patients was given in a dosage of 150 to 300 mg a day for two to four weeks and then discontinued if there was no improvement. In Shanghai the maximum daily dosage of chlorpromazine for inpatients was 600 to 700 mg when used alone and about 300 mg when combined with acupuncture and herbs.

We saw a variety of therapies at the Shanghai Psychiatric Institute. Group meetings of patients and staff seemed to be held regularly. A type of day care center in the form of a large recreation room was available for use by any patients who wished to go there. Carnival-style games, music, dance performances, and songs were held daily, with the patients themselves as the participants on stage and in the audience. Ping-pong and chess were played on the wards. Work was a regular activity. Jobs consisted of simple manual tasks: some patients wove small items, some put small paper fillers into toothpaste caps, and others worked in the hospital garden or helped with grounds maintenance. Articles made in the hospital were sold to factories, and proceeds went to buy recreational materials, books, ink, etc., for the patients' use.

Neuropsychiatric patients in Nanking were given "dis-

charge papers" upon their release from the hospital. These papers contained a list of medications, dosages, and the time and place of follow-up visits. Patients would usually return to the hospital to keep appointments. A different group of doctors and nurses from those who treated inpatients saw the patients in the outpatient department. The same therapist saw the patient on each visit, since the relationship between the therapist and the patient was felt to be important. Acupuncture was not given to discharged hospital patients in the outpatient department, in contrast to its use in the treatment of neurosis in various outpatient settings. Most relapses occurred within two years, and patients were advised to take their medications for at least that long after discharge.

At the Shanghai Psychiatric Institute, discharged patients returned to the hospital after two weeks to see the same doctor who had treated them on the ward. More visits could be scheduled as necessary. The doctor could help the patient in his readjustment at home and at work and would sometimes make visits to the factory or neighborhood on the patient's behalf. There was no social worker on the staff. Nurses worked with doctors in the outpatient department, but their role was not clarified. Unlike doctors, the nurses did not seem to alternate between the inpatient and outpatient departments.

Outpatient Care

Some mental health clinics in the cities were operated away from the hospital grounds, but little is known about them. An administrator of a local hospital in Shanghai informed us,

> Only an occasional mental patient is treated here [at this neighborhood hospital], and only on a temporary basis. Most of the follow-up is done in the district mental "prevention" clinics, which are open two to three days per week. These do outpatient follow-up and are staffed by the doctors and nurses from the mental hospital. The patients discharged from the mental hospital are given "trial discharges" and they return weekly for follow-up. They may be seen in the local hospitals like this one only for medicines or occasionally for emergencies. Those who need the closest outpatient supervision are given aftercare at the mental hospital instead of the district clinics.

In Nanking, neurotic outpatients were treated with sedatives, acupuncture, or other traditional techniques. There were no data on the number of neurotic patients, but they were said to be "very few." The diagnostic category of neurosis was broad and included symptoms like headache and "nerve pain." In general medical clinics, patients who were recognized as having no organic basis for their symptoms could be treated by internists or neurologists without requests for psychiatric referral. A physician in a general hospital in Peking stated, "Internists and other doctors treat neurotics in regular hospitals. They are treated with drugs and acupuncture. They are not admitted to the psychiatric hospitals." Bromides seemed to be commonly prescribed for nonspecific ailments. Phenobarbital was used frequently in factory and neighborhood health stations. A factory doctor and one of our guides each mentioned that they took small doses of perphenazine as often as several times a week to relieve tension.

Consultations were held between nonpsychiatric hospital personnel and staff from the mental hospital in Nanking. The consultations were reciprocal and seemed to be strictly case oriented.

Rehabilitation

The Chinese social structure appears to be very supportive of the mentally ill. Cooperation and the dignity of each citizen as part of the group are emphasized. The duties of the psychiatrist seem oriented toward enabling the patient to regain his position in his family and job. The whole matter appears capable of careful planning and execution from the time of the patient's original referral to a mental hospital to his reintegration in the community. Two case histories related by a physician at the Shanghai Psychiatric Institute illustrate this point.

> After a patient left our hospital and went back to his working unit, the authorities of that unit, in consideration of his health, shifted him to another workshop to do another kind of job. However, he took this in the wrong way. He thought that the administrator of this work unit might have some kind of prejudice against him, and he became very disappointed and returned to the hospital to ask the doctor's help. The doctor went to the working unit to learn about the whole process and to explain to the patient. The man gradually understood why his work was shifted, his disappointment disappeared, and he worked very well and was very pleasant.
>
> In another instance a patient had been a shop assistant in a department store. When he recovered and returned to his store, his leaders failed to understand him very well, and he was assigned to his original job. However, he was unable to adapt to the original job because the medicine interfered with his memory. Thus, he could not do accounts very well. When he came back to the hospital to ask for the doctor's help, the doctor went to this store and got the leaders to shift the patient's work. He became a warehouse keeper for a half year. His memory then recovered and he asked to do the same job he had held before.

Mobile Teams

One-third of the staff at the Shanghai Psychiatric Institute toured the surrounding countryside in mobile teams. This practice is common in all types of hospitals, general and specialized, and it represents an attempt to bring care closer to the people. The mental hospital teams consisted of three doctors and seven nurses. The whole staff took turns on mobile teams. An important duty of these groups was to train "barefoot doctors" in the management of acute psychiatric problems. Often the barefoot doctors could not immediately send psychiatric patients to the mental hospital, and they thus had to learn about drug and acupuncture treatment for such situations. One doctor reported, "The mobile team of the mental hospital came to our hospital a year ago. They gave two days of lectures at the hospital and worked in the clinics one week more to take measurements on rates of mental diseases."

It is apparent that much of the theory and practice of Chinese psychiatry is based on hospital practice. Almost all patients are sent to the hospital for treatment; follow-up care and community support for discharged patients is organized from the hospital. The hospital staff runs the outpatient departments and the outlying clinics and supplies the mobile teams that disseminate information on psychiatry to neighborhood and commune medical units. Private practice does not exist, and clinical research and training is hospital based.

TRAINING

Chinese medical students now receive instruction in neurology and psychiatry during a two-week series of lectures and visits to neuropsychiatric hospitals in their second year of medical college. Since the Cultural Revolution, medical students have had a three-year curriculum. Prior to the Cultural Revolution they studied for five or six years and received two weeks of psychiatric training in their fourth year (13). At present, psychiatry is part of the course in internal medicine, and lectures seem to be given by internists or neurologists. The departments of psychiatry that had formerly been a regular feature of medical colleges (8, 13) were suspended during the Cultural Revolution and have not yet been reinstated. It is not known whether separate departments of psychiatry will be reestablished in medical colleges. The whole field of psychiatry may be continuing its Cultural Revolution even though many other medical specialties have reorganized.

After they graduate from medical school, most doctors may have no further exposure to training in psychiatry until they come into contact with a mobile team from a regional mental hospital. The only literature we found in bookstores that dealt with psychiatry for non-psychiatrists consisted of manuals written for barefoot doctors. Several of these included concise descriptions of common manifestations of epilepsy, psychoses, and neurasthenia. The use of phenothiazines, barbiturates, and bromides was covered briefly. The manuals provided a picture of symptoms and of routine treatment. A small section of a recent manual for barefoot doctors discussed mental illness in this fashion. The section also discussed the concept that some mental illnesses are a reaction to an unspecified underlying disorder, perhaps recalling the pre-1949 influence of Adolf Meyer (26).

Psychiatrists receive their training in the mental hospitals. Graduates from the medical colleges are assigned to work in mental hospitals, apparently in numbers planned to fit the country's projected need for psychiatrists. The basic course lasts from 6 to 12 months, according to sources in Nanking and Shanghai. Taipale and Taipale (12) reported that two or three years of training were required, but this difference may indicate that the period of formal training in psychiatry has been reduced from what it was in 1972. Another explanation may be that the shorter period refers to the organized system of lectures and that the longer period refers to the total time required before a resident is felt by his peers and supervisors to be capable of fully independent work.

At the Shanghai Psychiatric Institute the psychiatry residents learned through practice, supervision, readings, and seminars. One doctor at the institute reported, "When the residents first come here, their psychiatric knowledge is quite limited, so we give them training for one-half to one year. In this period of time experienced doctors will give them guidance. They will acquire knowledge mainly through practice. They are assigned some books and literature to read, and through practice they will gradually be capable of doing independent work." The reading assignments consisted of compilations prepared by the teaching staff; students who read English were also assigned selections from texts such as those by Mayer-Gross, Slater, and Roth (25), Henderson and Gillespie (27), and Noyes and Kolb (28). The lectures for residents included topics such as neurology, neuropathology, neurobiochemistry, and psychopharmacology. Psychologists from the university were invited to present lectures from time to time, but they did not practice in the mental hospitals. This has been the case for many years (13).

Some foreign journals available to psychiatrists included *The American Journal of Psychiatry, Archives of General Psychiatry, Journal of Nervous and Mental Disease, British Journal of Psychiatry,* and *Acta Psychiatrica Scandinavica.*

Research efforts were directed toward examination of the effectiveness of therapy. A popular research topic seemed to be a search for the effects of combining Western and traditional Chinese methods of treatment. Chinese psychiatrists seemed uniformly interested in the current trends of basic laboratory research in the United States.

CONCLUSIONS

We have attempted to trace some developments in the history of psychiatry in China and to present a picture of the practice of and education in psychiatry as it has been applied in the People's Republic of China. The Chinese approach has had to deal with several large problems. One of these has been the need to expand services to meet the needs of the vast population. This has been approached by increasing the numbers of psychiatrists and mental hospitals to accommodate the severely mentally ill. Personnel and facilities had not existed in adequate numbers before 1949. Outpatient clinics have been developed, but little is known about them. The existing social structure has been used to advantage to help in the rehabilitation of discharged patients. Available psychiatric doctors and nurses are being used to train other medical practitioners in basic concepts and methods so as to increase the availability of care.

Another problem has been to develop a consistent theoretical approach to psychiatry, a difficulty not peculiar to the People's Republic of China. The special approach adopted by the Chinese emphasizes sociopolitical factors

whenever possible in theoretical formulations about psychiatry. Research has been pursued mainly in clinical studies, but these could be of great significance when published if they support the claim of decreased prevalence and incidence of almost all kinds of functional mental illness in the People's Republic.

Clearly, the available information about psychiatric practice in the People's Republic of China gives only a hint of the differences between our two systems. There has only been a preliminary and incomplete exchange of information to date, by travelers who cannot fully represent so complex a subject after relatively brief exposures. As West and East observe each other in the future, more exchanges and greater depth of contact may be expected to stimulate greater mutual interest and benefits.

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Mental Changes Associated with Hyperparathyroidism

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To document the point that hyperparathyroidism should be considered a possible cause of unexplained neurological and psychiatric symptoms, the authors present five case reports of confirmed primary hyperparathyroidism in which the patients initially appeared with problems that seemed mainly psychiatric. The presenting symptoms in these cases consisted of varying degrees of depression, catatonia, confusion, disorientation, fatigue, and lethargy; there was no associated bone or renal pathology in four of the cases. The authors include a review of the pertinent literature and a discussion of the effect of calcium and magnesium bivalent ions on the central nervous system associated with hyperparathyroidism. They conclude that more investigation of the role of magnesium in this disease seems warranted.

HYPERPARATHYROIDISM has been difficult to diagnose because it presents with such a wide variety of clinical symptoms (1, 2). It is a relatively "new" disease, and its clinical and hormonal dynamics are yet to be well understood (3), but fortunately it is now being recognized more frequently and earlier in its course. In this regard we feel that the widespread use of the 12-channel autoanalyzer (SMA-12) has been very important in creating a greater appreciation of hyperparathyroidism by bringing more incidental reports of hypercalcemia to the attention of physicians. It is also most fortunate that the laboratory finding of hypercalcemia is so consistent for this disorder because the clinical manifestations of hyperparathyroidism can be present in many different target organs of the body and give the clinician many surprises (4).

This paper gives particular attention to examples of hyperparathyroidism that presented only or chiefly with psychiatric symptoms. Also included is a discussion of the associated biochemical mechanisms that may create such symptoms.

CASE REPORTS

Case 1. Mr. A, a 63-year-old farmer, was initially admitted to the hospital for a cholecystectomy in July 1970. Ten days after what was considered to be a routine operation he became confused. It was initially suspected that he had developed postoperative hepatic failure; this was not confirmed by further investigation. He subsequently developed a thrombophlebitis of the right leg that was treated with anticoagulants and a broad-spectrum antibiotic.

Despite the improvement of his thrombophlebitis, the patient still showed signs of persistent confusion and occasional disorientation 15 days after the operation. His general physical condition had improved, however, and he was discharged from the hospital.

His confusion became even worse while he was at home; he was readmitted to the hospital four days after being discharged. Medical consultation was again obtained and a serum calcium determination of 11.9 mg/100 ml was noted, along with a serum phosphorus level of 1.0 mg/100 ml. Repeated determinations confirmed these findings and a diagnosis of primary hyperparathyroidism was made. A bone survey that included the teeth, phalanges, tibia, femur, radius, and skull revealed no radiographic changes compatible with hyperparathyroidism (see table 1).

On October 5, 1970, the patient was operated on. At this time a parathyroid adenoma measuring 1.5 cm by 2.5 cm was found near the inferior pole of the left lobe of the thyroid. The surgical pathology report identified it as a chief-cell adenoma.

This patient experienced a dramatic return to normal mental status within two weeks after removal of the adenoma. By that time he showed no mental confusion or other residual psychiatric symptoms. Since his discharge from the hospital he has gained 47 pounds.

The role of operative or postoperative stress as a pertinent factor in precipitating the symptoms of hypercalcemia is, of course, speculative. No evidence of bone or renal disease was found in this patient. Serum magnesium levels were not obtained.

Case 2. Rev. Mr. B, a 65-year-old clergyman, was admitted to the hospital in February 1967 with a 14-month history of progressive depression, constipation, fatigue, lethargy, and complaints of being "mentally dull." These symptoms, which had come on insidiously, were accompanied by occasional episodes of confusion, a 28-pound weight loss shortly before admission, and some incoordination of gross and fine movements of the hands.

The patient had had a resection of an adenocarcinoma of the soft palate three months before this admission, a duodenal diverticulectomy and appendectomy one year prior to admission, and a subtotal thyroidectomy for a benign thyroid adenoma 10 years previously. He had been under continuing psychiatric care for what was diagnosed as severe reactive depression just before the 1967 admission.

On admission, this patient's serum calcium determinations ranged from 15.7 mg/100 ml to 18.3 mg/100 ml. Serum phosphorus levels ranged from 3.5 mg/100 ml to 3.7 mg/100 ml. (Additional laboratory determinations are shown in table 1.) On the left side of the patient's neck, a palpable mass measuring

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TABLE 1
Clinical Measurements for Five Patients with Hyperparathyroidism

Clinical Measurement	Mr. A	Rev. Mr. B	Ms. C	Ms. D	Ms. E
Serum calcium	11.9 mg/100 ml	18.3 mg/100 ml	12.0 mg/100 ml	11.2 mg/100 ml	12.2 mg/100 ml
Serum phosphorus	1.0 mg/100 ml	3.5 mg/100 ml	2.4 mg/100 ml	2.6 mg/100 ml	2.5 mg/100 ml
Serum alkaline phosphatase	16 K-A units	10.8 K-A units	2.5 K-A units	24 K-A units	16 K-A units
Tubular reabsorption of phosphate	91.4 percent	80.6 percent	94.2 percent	—	—
24-hour urinary calcium excretion	179 mg/100 ml	523 mg/100 ml	320 mg/100 ml	410 mg/100 ml	—
Serum creatinine	1.35 mg/100 ml	5.4 mg/100 ml	1.2 mg/100 ml	0.8 mg/100 ml	1.0 mg/100 ml
Creatinine clearance	162 ml/minute	—	—	—	—
Serum electolytes	normal	normal	normal	—	normal
Blood urea nitrogen	16.8 mg/100 ml	60.5 mg/100 ml	11.0 mg/100 ml	14.2 mg/100 ml	20.0 mg/100 ml
I-131 uptake	—	9.4 percent	—	—	—
Bone survey	negative	positive	negative	negative	negative
Side of gland adenoma located	left	left	right	right	left
Type of adenoma	chief cell	chief cell	chief cell (mixed)	chief cell	chief cell

4.5 cm by 2.5 cm was noted. This mass was movable, smooth, well circumscribed, and nontender.

X rays of the skull showed a "salt and pepper" appearance suggestive of hyperparathyroidism. X rays of the hands demonstrated subcortical resorption of the phalanges, and X rays of the teeth showed absence of the lamina dura. Both of these are suggestive of hyperparathyroidism.

He was taken to the operating room on February 27, 1967. At this time a large parathyroid adenoma was removed near the inferior pole of the left lobe of the thyroid. The surgical pathology report described it as a chief-cell adenoma.

The patient showed remarkable improvement in his psychiatric symptoms; just three weeks after surgery he was considered to be mentally and emotionally "his old self." He has continued to be free of any mental symptoms, has regained most of the weight he had lost, and has returned to full-time activity in his profession.

Of particular interest is the fact that this patient experienced a recurrence of neuropsychiatric signs and symptoms at a time when he had become profoundly hypocalcemic. These symptoms were treated by intravenous calcium therapy. However, with a return to eucalcemic levels, the symptoms were not significantly improved until magnesium sulfate was added to the therapeutic regimen.

Case 3. In July 1970, Ms. C, a 56-year-old housewife, was transferred from the psychiatric ward of another hospital where she had been treated for catatonic schizophrenia for four months. A newly assigned medical student who was in the process of reevaluating the case for his staff physician ordered a serum calcium test that reported a level of 12.0 mg/100 ml.

Further studies and additional serum calcium determinations ranged from 11.8 mg/100 ml to 12.6 mg/100 ml, serum phosphorus levels varied from 2.4 mg/100 ml to 2.6 mg/100 ml, and the serum alkaline phosphatase was 2.5 K-A units. All other laboratory data, including serum electrolytes, protein electrophoresis, the cortisone suppression test, tubular reabsorption of phosphate (TRP), phosphate deprivation tests, and calcium infusion and calcium urinary excretion tests, were within normal limits (see table 1). An extensive radiographic bone survey also demonstrated no abnormal findings, and intravenous pyelography and renal function studies were within normal limits.

On July 18, 1970, a parathyroid adenoma was removed near the inferior pole of the right lobe of this patient's thyroid measuring 3.0 cm by 2.0 cm. The surgical pathology report described this as a mixed-type parathyroid adenoma with a chief-cell component. By the third day after the operation, Ms. C's serum calcium had dropped to 7.8 mg/100 ml; it returned to a normal range 13 days after surgery.

It should be noted that exhaustive screening procedures had not revealed any evidence of bone or renal disease in this patient. Although the diagnosis was made mainly by serendipity, the patient has made a gradual recovery from her psychiatric illness. The attending psychiatrist feels her progress has been exceptionally good and attributes this to the parathyroidectomy. She has not been given any medication for her mental illness since the surgery.

Case 4. Ms. D, a 74-year-old housewife, was admitted to the psychiatric service of the hospital in May 1971 with a diagnosis of involutional depression. In the course of her evaluation it was noted that she had an elevation of her serum calcium to 11.2 mg/100 ml and a serum phosphorus depression to 2.6 mg/100 ml. These abnormal findings were confirmed by repeated determinations (see table 1).

A radiographic bone survey revealed some osteoarthritic changes in the interphalangeal joints but did not demonstrate any findings suggestive of hyperparathyroidism. Chest X ray revealed a calcified granuloma in the right mid-lung field but no other abnormalities. An intravenous pyelography showed only a mild ptosis of the right kidney. X rays of the teeth showed some cavity formation and alveolar recession but no absence of the lamina dura. An I-131 uptake at 24 hours was 8.7 percent, which is considered to be in the hypothyroid range.

On June 8, 1971, a parathyroid adenoma near the inferior pole of the right lobe of the thyroid was excised. The surgical pathology report described it as a chief-cell adenoma. The patient had a remarkably easy postoperative recovery. Her depression disappeared without the use of antidepressant medication and her psychiatrist confirmed that she continued to do very well three years after surgery.

It should be noted that the value of the SMA-12 as a routine screening instrument is well demonstrated in this case. It might very well be a part of the routine evaluation of patients in mental institutions. The rapidity with which the diagnosis was determined in case 4 was directly related to the early recognition of the presence of hypercalcemia. Unfortunately, no magnesium levels were obtained on this patient to correlate with her changing symptomatology.

Case 5. Ms. E, a 75-year-old housewife, was admitted to the neurology service of the hospital in May 1972 for the investigation and treatment of a suspected cerebral vascular accident. She was a known diabetic, adult-onset type, and had been hypertensive. She also had a history of recent syncope, progressive confusion, and drowsiness.

An SMA-12 blood chemistry profile indicated that she had an elevated serum calcium of 12.6 mg/100 ml and a decreased phosphorus level of 2.4 mg/100 ml. On subsequent determinations serum calcium was 12.2 mg/100 ml and serum phosphorus was 2.5 mg/100 ml (see table 1). A radiographic bone survey and serum alkaline phosphatase test were within normal limits.

On May 20, 1972, a parathyroid adenoma was removed near the inferior pole of the left lobe of this patient's thyroid gland. The surgical pathology report described it as a chief-cell adenoma.

Ms. E had an uneventful surgical recovery and, according to the referring physician, experienced a remarkable improvement in her neuropsychiatric condition. She is currently receiving no medications, her diabetes is well controlled, and she remains normotensive.

The blood chemistry SMA-12 profile obtained on admission was very valuable in alerting the attending neurologist to the possibility of a parathyroid adenoma in this case.

DISCUSSION

Literature Survey

In the literature on hyperparathyroidism, comparatively little attention has been given to the psychiatric symptoms often associated with it. The mechanism by which these symptoms are produced remains unknown. They are believed to be related in some way to the associated hypercalcemia, but other factors may be involved as well.

The psychiatric symptoms most commonly described are those associated with an acute brain syndrome or general depression of mental function. Soon after parathyroid hormone was isolated, Collip (5) reported an apparent psychic depression in test animals receiving parathyroid hormone. Boyd and associates (6) described a case of hyperparathyroidism with associated symptoms of "marked lassitude of the body and mind." After their patient's parathyroid adenoma was removed, mental alertness returned. Investigating this and other reports, Hannon and associates (7) discovered that twice the amount of electrical current was required to excite an isolated nerve in a patient with hyperparathyroidism.

Over the next few years, several clinical cases were reported showing "mental retardation," "listlessness," "apathy," and "disorientation" (8–13). Harmon (13) also noted two unusual findings in a case of hyperparathyroidism in a six-year-old child—permanent neurological damage and a serum magnesium deficit. Eitinger (14) reported evidence of mental symptoms in 7 of 50 descriptions of primary hyperparathyroidism in 1942. He presumed these were related to hypercalcemia. Chaplin and associates (15), reporting on vitamin D intoxication, referred to a "mild psychosis" in patients with elevated serum calcium.

Among the more recent reports, Karpati and Frame (16) presented the first review of neuropsychiatric disorders in hyperparathyroidism. They wrote:

> It is surprising that neuromuscular signs and symptoms are not more often reported in patients with hyperparathyroidism in view of the characteristic disturbances of calcium homeostasis and the prominent role of this bivalent ion in the electrobiology of nervous and muscle tissue. (16)

They also noted either psychiatric or neuromuscular findings in 14 of 23 cases of hyperparathyroidism. Improvement in mental symptoms followed surgery, although 3 patients in the series had acute psychotic episodes three to four days following surgery but then recovered rapidly and without residual symptoms. (In many respects these cases resemble our case 2.)

Potts and Roberts (17) also described two cases in which removal of a parathyroid adenoma was followed by confusion and psychotic behavior. Bergeron and associates (18) observed the same phenomenon and noted that serum magnesium levels were depressed, and in some cases the abnormal mental behavior improved after the administration of magnesium (note our case 2).

Various reports in recent years (19–24) tend to repeat the findings described previously, but a few of these cases reported symptoms that are not typical of the usual acute brain syndromes, such as delusions and aggressive behavior. Some of these cases were complicated by the preexistence of other physical diseases or mental disorders (as may be true in our case 3, who presented with schizophrenic symptoms, and case 4, who showed the apparent symptoms of involutional depression).

Possible Causes

In all of the reports on hyperparathyroidism in which some mention of mental symptoms has been included, no explanation has been offered for their cause except for the general dampening effect that hypercalcemia seems to have on any neurological function. Although an unproved cause, this does seem to be a reasonable assumption, even though the exact means by which calcium ions have this dampening effect is not understood. The effect of metallic ions on the functioning of the nervous system, and indirectly on human behavior, has received additional interest recently because of the use of lithium therapy for manic states. Since lithium has a dampening effect similar to that of calcium ions, it is intriguing to

consider what possible value calcium salts might have if used to amplify or substitute for lithium action.

Another metallic ion effect that may be significant in hyperparathyroidism is the influence of magnesium. Because of magnesium's metabolic interrelationship with calcium, the neurologic sequelae of depletion of body magnesium is certainly a mechanism deserving further consideration. Magnesium deficiency has been demonstrated to occur in hyperparathyroidism. This could be as important a causal factor as increased calcium.

In humans, magnesium deficiency is characterized by neuromuscular irritability and convulsions as well as confusional states and mental depression. Both calcium and magnesium in higher concentrations tend to depress the excitability of the myoneural junction, whereas high magnesium concentrations have a definite central depressive effect ("magnesium narcosis") that can be reversed by the administration of calcium (25).

During the hyperparathyroid state there is a negative magnesium balance, with increased urinary excretion of magnesium and a variable serum magnesium level. This is due in part to the mobilization of magnesium along with calcium from bone. If magnesium is cleared through the kidneys more rapidly than calcium, increased levels of urinary magnesium without elevated serum magnesium can result.

Removal of the cause of the hyperparathyroid state creates a positive magnesium balance and retention of magnesium intracellular components accompanied by a decrease in serum and urinary magnesium. A closer study of magnesium intra- and extracellular alterations in hyperparathyroidism certainly is warranted. These alterations may prove to be very significant in both the preoperative and postoperative mental disorders in hyperparathyroidism.

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The Effect of Living Alone on Bereavement Symptoms

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The author reports on a study of widows and widowers who were followed for one year after the deaths of their spouses. The study shows that bereavement itself rather than the effects of living alone influences the occurrence of depressive symptoms in widows and widowers at one month. The data gathered also support the idea that younger people who have lost a spouse tend to show more physical depressive symptoms and to require hospitalization more often than either matched married controls or older widows and widowers at one year.

MY COLLEAGUES AND I have investigated social isolation as a cause of bereavement symptoms as part of a prospective study of widowhood. In previous reports (1, 2), we noted a high prevalence of physical and psychological symptoms of depression in the first year of widowhood. Similar symptoms have been reported in other prospective and retrospective studies of widowhood, beginning with Freud (3) and continuing with Lindemann (4), Marris (5), Maddison and Viola (6), Yamamoto and associates (7), Parkes (8), Kennell and associates (9), and Heyman and Gianturco (10).

Using specific diagnostic criteria for depression, we have shown that, in addition to individual psychological and somatic symptoms of depression, 35 percent of our sample of widows and widowers had a depressive syndrome one month after their bereavement (11) and 17 percent had this same syndrome one year later (12). Forty-six percent of the sample experienced this cluster of depressive symptoms at some time during the first year of bereavement and 13 percent had the syndrome for the entire year (13).

The question arises of whether these symptoms are due to the bereavement itself or to the loneliness and social isolation that result from the bereavement. To answer this question, we divided our widows and widowers into those who lived alone and those who lived with someone (children, siblings, or parents) after the bereavement. We then compared the two groups on many variables, including the presence of depressive symptoms, one month after bereavement and again at one year.

We also followed a group of age-matched, married controls longitudinally and compared the prevalence of depressive symptoms over a one-year period in the four groups—the widows and widowers who had lived alone were compared with their controls, and those who had not lived alone were compared with their controls.

METHOD

The method of this study has been described fully elsewhere (1, 2, 11, 12). From the death certificates of the city and county of St. Louis we chose names of men and women who had recently been widowed. A table of random numbers was used to select subjects for interview. We saw 109 people who had been widowed for no longer than one month. These included 76 women and 33 men whose average age was 61. We saw these people in their homes for approximately two hours, using a systematized and open-ended interview.

Shortly after we selected our study population, we matched them through the voter registry with married people of the same age and sex and from the same voting district, preferably from the same street. We interviewed the bereaved again at four months. At one year we interviewed the bereaved and their married controls. We were particularly interested in mortality in the widows and widowers and morbidity as measured by presence of depressive symptoms, physician visits, drug use, and hospitalizations during the previous year.

The criteria for diagnosis of depression in this study are those recommended by Feighner and associates (14). The criteria were feeling depressed or feeling lost or numb plus four of the following eight symptoms: anorexia or weight loss; sleep disturbance, including hypersomnia; fatigue; feeling restless; loss of interest; difficulty concentrating; feeling guilty; and wishing to be dead or thoughts of suicide. This cluster had to be present at the time of the interview for a diagnosis of depression to be made.

Statistical evaluation of the data presented in this report was accomplished by means of the chi-square test with Yates' correction and the t test for data requiring parametric evaluation. Both statistics were used as two-tailed tests. Differences were defined as significant when there was 1 or less than 1 chance in 20 that they had occurred by chance.

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RESULTS

One-Month Follow-Up

At one month we examined symptoms in 108 widows and widowers. One man in the original sample was in a nursing home and had a chronic brain syndrome; it was felt for this particular evaluation it was best to exclude him. Sixty-one (56 percent) of the 108 people were living alone at one month and 47 (44 percent) were not living alone. Forty were living with children, 4 with siblings, and 3 with parents. The average age of those living alone was 65; for those not living alone it was 58 ($p<.01$). This difference is due to the fact that almost all of the younger people in the study (particularly the women) had young children and were therefore not considered to be living alone.

There were approximately equal percentages of women in both groups: 67 percent of those living alone were women and 74 percent of those not living alone were women. There were no differences in the two groups in socioeconomic status, length of illness of the deceased, or assessment of the marriage before the illness as good or poor. Depressed mood, sleep disturbance, crying, anorexia, weight loss, difficulty concentrating, poor memory, loss of interest, fatigue, diurnal variation, feelings of worthlessness, feeling that one is a burden, feeling guilty, feeling hopeless, wishing one were dead, and suicidal thoughts all occurred with equal frequency in both groups.

Equal numbers of both groups lost a small or large amount of weight in the first month after bereavement; more of those living alone gained weight (12 percent versus 2 percent). Restlessness occurred in 63 percent of those living alone and 24 percent of those not living alone ($p<.05$). Irritability occurred in 8 percent of those living alone and 26 percent of those who were not living alone ($p<.05$).

Considering the number of variables we examined, it would be difficult to say that these differences did not occur by chance alone. Irritability has been associated in our previous studies with younger age. This is most likely due to the fact that younger people had someone against whom to direct their irritability (e.g., children).

Using the criteria for depression described above, 34 percent of those living alone and 36 percent of those not living alone were given a diagnosis of depression. Physical symptoms such as headaches, blurred vision, dyspnea, abdominal pains, constipation, attacks of anxiety, urinary frequency, dysmenorrhea, and other pains, especially joint and back pains, were inquired about. There were no differences in the occurrence of these symptoms in the two groups. There were also no differences in the use of hypnotics or tranquilizers or in visits to a physician. This means that those who were living alone did not necessarily go to their physician just because they had no one to talk to. Thus social isolation did not seem to influence the psychological symptoms, physical symptoms, or medical treatment of the widows and widowers during the first month after bereavement.

One-Year Follow-Up

Of the 47 widows and widowers who were not living alone one month after bereavement, 7 were living alone one year later. Most of these people had children who married or went into the service. Three people who had been living alone were no longer living alone at one year. In this population of 108 people, 9 percent changed their intimate living arrangements during the first year after bereavement.

At one year we followed up 94 people (86 percent of the original sample). Four of these people had died, leaving 90. The man in the original sample who was in a nursing home with a chronic brain syndrome was one of those who died. By one year one woman was in a nursing home and had a severe chronic brain syndrome; she was excluded from the calculations. At the one-month follow-up this woman had had a mild diagnosable chronic brain syndrome.

Our one-year data deal with 89 people. Fifty-two (58 percent) were living alone and 37 (42 percent) were not. Of those who were not living alone, 29 were living with children, 2 were living with siblings, 3 with their mother, 1 with a niece, 1 was a housemother, and 1 man had remarried. The average age of those living alone was 63, of those not living alone, 57 ($p<.05$).

Again there were no differences in the percentage of women in each group or in the socioeconomic status of the groups. Both groups reported with equal frequency previous separation, divorce, or unhappiness in the marriage from which they were widowed; these factors did not seem to influence whether or not they lived alone.

Table 1 shows the incidence of psychological and somatic symptoms of depression as well as the depressive syndrome in these groups at one year. The frequencies represent the presence of these symptoms. There was a tendency for those living alone to report depressed mood and sleep disturbance more often, but this trend did not achieve significance. Those living alone also felt more often ($p<.05$) they had nothing to look forward to and had a tendency to feel hopeless and to wish they were dead. Thus there is a slight indication that living alone produces more psychological distress a year after the bereavement. This is further emphasized by the finding that those who had a collection of depressive symptoms were mainly in the group living alone.

It was also found that equal numbers in both groups lost a small or large amount of weight or gained weight. Most of the widows and widowers also dreamed infrequently about the deceased spouse. Two-thirds of those living alone and one-half of those living with someone had "good" dreams.

Table 2 shows that those living alone had no more physical symptoms and received no more medical treatment, with the exception of the use of hypnotics, than those not living alone. The finding of the use of hypnotics lends credence to the previous statement that there is more distress in those living alone.

It was also found that 35 percent of those living alone related their visits to physicians to grieving while only 18

percent of those not living alone did so. The two groups had similar numbers of visits to physicians.

A large number of physical symptoms showed no differences between the two groups. These included the following: headaches, blurred vision, dyspnea, chest pains, palpitations, anxiety attacks, abdominal pains, vomiting, constipation, urinary frequency, dysmenorrhea, other pains (especially in the back and joints), dizziness, fainting, skin rashes, excessive sweating, and increased or decreased smoking.

Other variables compared included problems experienced since the death, advice sought about these problems as well as more general advice, financial support, spending habits, working habits, socializing, drinking habits, and changes in day-to-day habits such as cooking, cleaning, and taking care of personal appearance. No differences were found between groups on these variables.

We also found no differences between groups in feelings about the marriage, the illness, the death, the funeral, visiting the grave and specific thoughts about the deceased (e.g., thinking about him or her daily, sensing his or her presence, cultivating that presence, or avoiding reminders of the deceased).

No differences were found in feelings and actions regarding dating, sex, and remarriage. Twelve percent of those who were living alone reported having a severe reaction on the anniversary of their spouse's death; no one who was living with someone reported this reaction. A severe reaction was defined as a syndrome of more than one day's duration with a low mood described as "miserable" or its equivalent, excessive crying in places other than the church or grave, and/or work function interrupted. The difference was not significant, but it may be that one year after the bereavement living with someone attenuates this reaction as well as other symptoms.

Comparisons with Matched Controls

Table 3 shows depressive symptoms in those living alone and those not living alone and their matched married controls. The frequency of each symptom is not shown. Rather, the table shows whether the subjects and controls had had the symptom at any time during the year. There are marked differences between our subjects and their controls on a large number of depressive symptoms. Widowed subjects, living alone or not, could expect to experience a number of distressing psychological and somatic depressive symptoms in the first year compared with controls. No group reported suicidal thoughts with any great frequency.

Table 4 shows that there are differences in some physical symptoms (mainly in subjects not living alone—the younger group). However, a large number of other physical symptoms show no differences. General poor health was no different between subjects and controls.

Table 5 shows medical treatment for the subjects and their controls. Here the only difference that emerges is a difference in hospitalizations, which occur more often in subjects living with someone (the younger group), and in the use of hypnotics in subjects living alone.

TABLE 1

*Depressive Symptoms in Subjects at One Year, in Percents**

Symptom	Subjects Living Alone (N = 52)	Subjects Not Living Alone (N = 37)
Depressed mood	58	35
Sleep disturbance	60	38
Crying	40	30
Anorexia	15	14
Weight loss	16	19
Difficulty concentrating	12	8
Poor memory	23	16
Loss of interest	23	14
Irritability	10	14
Restlessness	37	19
Fatigue	31	32
Diurnal variation	10	11
Reverse diurnal variation	33	19
Dreams about deceased spouse	69	54
Feeling worthless	13	11
Nothing to look forward to	33**	11
Feeling guilty	2	16**
Feeling hopeless	21	5
Wishing one were dead	19	8
Suicidal thoughts	2	3
Depersonalization	0	0
Derealization	4	5
Hallucinations	6	5
Fear of losing mind	2	5
Feeling angry	9	16
Feeling someone is to blame	17	24
Depressive symptom cluster	27***	5

*Percents represent positive responses.
**$p < .05$.
***$p < .025$.

TABLE 2

*Physical Symptoms and Medical Treatment in Subjects at One Year, in Percents**

Item	Subjects Living Alone (N = 52)	Subjects Not Living Alone (N = 37)
Three or more physical symptoms	40	38
General poor health	12	8
Use of tranquilizers	33	28
Use of hypnotics	39**	14
Physician visits or medicines sent by physician	88	81
Hospitalizations since death of spouse	17	30

*Percents represent positive responses.
**$p < .025$.

DISCUSSION

The overwhelming evidence of this analysis indicates that the bereavement itself, rather than the effects of loneliness or social isolation, influences the occurrence of depressive symptoms as well as medical attention for symptoms one month after the loss of a spouse. The be-

TABLE 3
*Depressive Symptoms in Subjects and Matched Controls at One Year, in Percents**

Symptom	Living Alone			Not Living Alone		
	Subjects (N=52)	Controls (N=52)	Significance	Subjects (N=37)	Controls (N=37)	Significance
Depressed mood	94	19	$p < .0005$	84	6	$p < .0005$
Crying	98	12	$p < .0005$	95	6	$p < .0005$
Sleep disturbance	85	38	$p < .0005$	76	27	$p < .0005$
Anorexia	46	0	$p < .0005$	57	3	$p < .0005$
Difficulty concentrating	37	6	$p < .0005$	32	11	$p < .05$
Loss of interest	48	10	$p < .0005$	49	6	$p < .0005$
Fatigue	54	23	$p < .005$	57	27	$p < .01$
Weight loss	48	29	n.s.	46	16	$p < .01$
Poor memory	48	27	$p < .05$	49	22	$p < .05$
Feeling guilty	25	8	$p < .05$	30	0	$p < .005$
Feeling hopeless	27	4	$p < .005$	8	3	n.s.
Wishing one were dead	25	8	$p < .05$	8	3	n.s.
Diurnal variation	17	15	n.s.	22	11	n.s.
Irritability	21	23	n.s.	30	11	n.s.
Restlessness**	44	33	n.s.	22	30	n.s.
Feeling worthless	13	15	n.s.	14	6	n.s.
Suicidal thoughts	4	0	n.s.	3	0	n.s.
Fear of losing mind	2	4	n.s.	5	3	n.s.
Hallucinations	13	4	n.s.	11	0	n.s.
Feeling one is being talked about	6	2	n.s.	5	6	n.s.
Derealization	6	4	n.s.	8	0	n.s.

*Percents represent whether the subjects and controls had the symptom at any time during the year.
**$p < .05$ for subjects living alone versus subjects not living alone.

TABLE 4
*Physical Symptoms in Subjects and Matched Controls at One Year, in Percents**

Symptom	Living Alone			Not Living Alone		
	Subjects (N=52)	Controls (N=52)	Significance	Subjects (N=37)	Controls (N=37)	Significance
Shortness of breath	25	10	n.s.	32	6	$p < .01$
Palpitations	21	4	$p < .025$	11	3	n.s.
Blurred vision	23	12	n.s.	27	6	$p < .05$
Abdominal pains**	15	19	n.s.	30	3	$p < .005$
Other pains, especially in back and joints	40	40	n.s.	62	32	$p < .025$
Headaches	29	25	n.s.	35	14	n.s.
Chest pains	17	15	n.s.	16	14	n.s.
Anxiety attacks	13	8	n.s.	11	3	n.s.
Vomiting	6	10	n.s.	5	6	n.s.
Constipation	33	31	n.s.	32	22	n.s.
Frequent urination	29	35	n.s.	35	22	n.s.
Dizziness	13	17	n.s.	19	22	n.s.
Fainting spells	0	10	n.s.	8	3	n.s.
Excessive sweating	10	6	n.s.	8	11	n.s.
General poor health	12	8	n.s.	8	8	n.s.

*Percents represent positive responses.
**$p < .05$ for controls living alone versus controls not living alone.

reavement also influences the occurrence of symptoms over the period of a year. There is some indication from the data that the younger widows and widowers living with someone had more physical symptoms and more hospitalizations in the year after bereavement than their controls and the older widows and widowers. Parkes (8) and Maddison and Viola (6) have demonstrated that younger people show more physical symptoms in response to bereavement than older people. These findings support that idea.

It may be that those living alone experience more depressive symptoms and more depressive syndromes than those living with someone one year after bereavement. Thus with time those living with someone do better. Be-

TABLE 5
*Medical Treatment in Subjects and Matched Controls at One Year, in Percents**

Treatment	Living Alone			Not Living Alone		
	Subjects (N=52)	Controls (N=52)	Significance	Subjects (N=37)	Controls (N=37)	Significance
Any physician visits	88	79	n.s.	76	84	n.s.
Three or more physician visits**	63	63	n.s.	54	38	n.s.
Psychiatrist visits	4	0	n.s.	3	0	n.s.
Hospitalizations	17	21	n.s.	30	6	$p < .025$
Medical	10	12	n.s.	22	3	n.s.
Surgical	6	13	n.s.	11	3	n.s.
Psychiatric	2	0	n.s.	3	0	n.s.
Use of medicine for general health	40	63	$p < .05$	54	54	n.s.
Use of hypnotics***	39	13	$p < .01$	14	16	n.s.
Use of tranquilizers	33	23	n.s.	28	19	n.s.

*Percents represent positive responses.
**$p < .05$ for controls living alone versus controls not living alone.
***$p < .025$ for subjects living alone versus subjects not living alone.

cause so many of the comparisons were negative, a replication study is necessary to show that the positive findings were real and not due to chance.

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The Validity and Significance of the Clinical Diagnosis of Hysteria (Briquet's Syndrome)

BY SAMUEL B. GUZE, M.D.

The author states that a valid diagnostic classification based on the medical model is a sine qua non for progress in psychiatric research and treatment and that such classification requires follow-up and family studies. To illustrate this point he reports on studies showing that hysteria, or Briquet's syndrome, is a valid clinical entity that follows a predictable course and clusters in certain families. He also reports that an association between hysteria and sociopathy has been demonstrated, suggesting that the two conditions may arise from similar etiologic and pathogenetic factors.

THE EFFORTS OF MY COLLEAGUES and me to study hysteria and related conditions derive from our views about psychiatric diagnosis. We believe that a valid diagnostic classification is a sine qua non for progress in understanding the nature and causes of psychiatric disorders and for developing effective treatments.

There was a time when many psychiatrists rejected the possibility, desirability, or necessity of valid diagnostic classification. They argued that such efforts to label patients were misleading and antihumanitarian. They argued that labeling a patient undermined therapeutic optimism and led to therapeutic failure. They never supplied data to support their assertions, but their views received widespread attention and respect.

Today, although few leaders in psychiatry openly champion this position, it has been adopted by many in the field and has found many nonpsychiatrist adherents. The latter are found chiefly among various so-called radical groups, including some social scientists, political activists, and a variety of social critics who are anti-establishment and antimedical. Their objection to diagnosis stems from a rejection of the medical model of psychiatric disorders. This rejection reflects a misunderstanding of the nature of this model and an unwillingness to accept any view of psychiatric disturbance that does not see it as a reaction to negative social, economic, and cultural forces in Western technological capitalist society.

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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THE MEDICAL MODEL

As I have argued elsewhere (1, 2), the medical model requires no assumptions about etiology or effective treatment. It assumes only that there are different psychiatric disorders with different clinical pictures, natural histories, etiologies, and mechanisms and that different disorders will respond best to different treatments. This assumption results in efforts to divide psychiatric disorders into homogeneous groups based upon common etiology, pathogenesis, clinical features, and response to treatment. Features that patients have in common are the major focus of concern. Diagnosis is the medical term for this kind of classification. Its essential role is implicit in the medical model. Physicians have traditionally worked to recognize and characterize different illnesses and to distinguish one from another.

The causes of most psychiatric disorders are not known; they will become known only through research. Dogmatic assertions about etiology cannot be justified and cannot be considered adequate grounds for rejecting the medical model.

The medical model may be contrasted to its principal alternatives. The first alternative presupposes a general vulnerability to psychiatric disturbances in each individual, presumably as the result of early life experiences. The particular form of the disturbance is of secondary concern and is explained in terms of chance individual and environmental circumstances and in terms of the severity of the disturbance. Research into the nature of psychiatric disturbance and efforts at treatment are primarily directed at the hypothetical general vulnerability. The individual—his idiosyncratic circumstances, life history, and reactions—is the focus of concern.

The second principal alternative is based on the assumption that the social, economic, and political context of psychiatric disorders is of primary etiologic importance. Again, the form of the psychiatric condition is given little weight; diagnosis is minimized or ignored. Frequently—perhaps usually—the two alternative viewpoints are combined.

Although these descriptions are brief and incomplete, they indicate the thrust of the conflicting views. It is difficult to understand how experienced clinicians can fail to see that psychiatric disorders come in many different forms, that they are distinguishable from one another by more factors than simply their severity, and that classification or diagnosis is inevitable.

DIAGNOSTIC VALIDITY

What then is the best way to classify psychiatric disorders? I have elsewhere (1, 2) presented an approach that permits a "bootstrap operation," which offers hope for achieving, in time, a valid, generally accepted diagnostic classification.

Attempts to validate a clinical diagnosis should begin with a reasonably clear clinical description of the cases to be included within the particular category. One may start with a single striking manifestation or with a combination of manifestations, depending on previous clinical experience or intuition. Having defined the clinical category, the validity of the diagnostic grouping will depend upon demonstrating a common etiology, a similar pathogenesis (similar changes in anatomy, physiology, or chemistry), a uniform clinical course, and, in at least some disorders, an increased prevalence of the same illness in close relatives of index cases.

A completely validated category would require demonstrating all these points; such validation may be achieved only infrequently, as with certain specific gene-linked disorders such as sickle-cell anemia or phenylketonuria. For most clinical disorders, complete diagnostic validity has not been established and further reclassification is necessary.

The process of diagnostic validation is based on viewing clinical diagnosis as a prediction. Diagnosis should predict etiology, pathogenesis, clinical course, and familial illness patterns. A degree of diagnostic validity is established to the extent that it does predict these factors. For the common psychiatric disorders, too little is known about etiology or pathogenesis to validate diagnoses using these measurements. Tentative diagnostic validity must therefore depend upon clinical course and familial illness patterns.

Follow-Up Studies

The important question to be answered is, Do a significant number of patients with a particular diagnosis show the diagnostic features of another illness at follow-up? If they do, it would suggest that the original sample was not homogeneous and that the diagnostic criteria should be modified to correctly predict this differential outcome. Follow-up studies also contribute to diagnostic validity through analysis of prognosis. Marked differences in prognosis, such as between complete recovery and chronic persistent illness, suggest that the diagnostic group is not homogeneous and, again, that revision of diagnostic criteria may be indicated. A variable prognosis is not as logically compelling in indicating diagnostic heterogeneity as is a change in diagnosis; the same illness may have a varied outcome. Until more is known about the basic nature of psychiatric disturbances, however, gross differences in prognosis challenge the validity of a diagnosis.

If follow-up study indicates that few of the original cases appear with diagnostic features of another disorder, and if the prognosis of all of the cases has been generally similar, one may conclude that the original diagnostic grouping has been tentatively validated.

Family Studies

Family studies are important in investigating the etiology of illness. They are also important in the validation of diagnosis. An increased prevalence of the same disorder among close relatives of index cases suggests that one is dealing with a valid entity, independent of etiology. Since not all illnesses necessarily show familial segregation, the absence of an increased family prevalence cannot contribute to the question of diagnostic validity.

In summary, a psychiatric diagnosis may be considered tentatively valid if patients with a specific diagnosis do not show diagnostic features of a different illness at follow-up, if they have had a similar course, and if an increased prevalence of the same condition is encountered among close relatives. Thus the establishment of diagnostic validity requires follow-up and family studies.

DEFINITION OF TERMS

The application of these principles to the diagnosis of hysteria first requires attention to definitions. Two related terms are encountered frequently in the literature: "conversion symptom" (or conversion reaction) and "hysteria." The careless use of these terms may result in confusion. Most authors fail to indicate how they use these terms and do not make clear whether or not they regard them as equivalent. For some the terms refer to individual symptoms and for others to personality styles or symptom patterns. Patients described under these labels may include such diverse groups as young girls with sudden amnesia, middle-aged men with severe depression who complain of persistent abdominal pain, known epileptics with puzzling spells, patients with early disseminated sclerosis, and women with dystonic reactions to phenothiazines. No wonder there is some despair regarding the usefulness of psychiatric diagnosis!

The studies summarized below were based on differentiating between conversion symptom and hysteria. A gratifying degree of diagnostic validity is evident when conversion symptom and hysteria are used to refer to different phenomena.

Conversion Symptom

Conversion symptom refers, in a purely descriptive way, to an unexplained symptom suggesting neurological disease. Amnesia, unconsciousness, paralysis, spells, aphonia, urinary retention, difficulty in walking, anesthesia, and blindness are common and classic examples of the so-called pseudoneurological or grand hysterical symptoms. To call these symptoms unexplained means only that the history, neurological examination, and appropriate diagnostic tests have not uncovered a satisfactory explanation for them. The use of the term in this sense carries no etiologic or pathogenetic implications.

Although the term "conversion symptom" derives from the psychoanalytic theory of the unconscious conversion of psychic energy, its use should be restricted. Unexplained pains or other unexplained medical symptoms should be excluded from the category of conversion symptom to preserve greater specificity. If such unexplained medical symptoms as headaches, backaches, and abdominal pains were included, the term would come to mean nothing more than an unexplained medical symptom. Its differential diagnosis would include the whole range of medical disorders.

Hysteria

Hysteria, on the other hand, is used to refer to a syndrome first systematically described by Briquet in 1859 (3). It was recharacterized by Savill in 1909 (4) and by Purtell and associates in 1951 (5). These authors described a polysymptomatic disorder seen predominantly in females. It begins early in life, usually before the age of 20 and nearly always before the age of 30, and is characterized by recurrent or chronic ill health, the complicated history of which is frequently described dramatically.

Characteristic features of the clinical history, most of which are to be seen in all patients, include many and varied pains, anxiety symptoms, gastrointestinal disturbances, urinary symptoms, menstrual difficulties, sexual and marital maladjustment, nervousness, mood disturbances, and conversion symptoms. Frequent visits to physicians, the use of a large number of medications, excessive hospitalizations, and excessive surgery are also seen in the florid symptom picture. To avoid ambiguity and the pejorative implications associated with the term "hysteria," I have proposed calling this symptom complex Briquet's syndrome as an equivalent diagnosis that is free of prejudice and unburdened by historical conflicts (2).

I would like to emphasize the following point: conversion symptoms are individual symptoms while hysteria is a polysymptomatic disorder.

RESULTS OF INVESTIGATIONS

The following conclusions are derived from a series of interconnected follow-up and family studies from the Department of Psychiatry, Washington University School of Medicine, St. Louis, over the past 15 years.

Hysteria, or Briquet's syndrome, is a recognizable syndrome that is very similar from patient to patient and may be identified by standard clinical examination. It generally runs a prolonged course over many decades, although there may be fluctuations in intensity (6, 7).

Conversion symptoms, on the other hand, may be seen in a wide range of psychiatric, neurologic, and general medical disorders, including hysteria (2, 8). They may also be seen in patients who show no other evidence of illness (2). The course and prognosis of patients with conversion symptoms are variable, depending upon the underlying disorders (8). Hysteria and sociopathy[1] are two of the most common psychiatric disorders associated with conversion symptoms (8).

Hysteria runs in families. About 20 percent of first-degree female relatives may suffer from the same disorder; male relatives show an increased prevalence of sociopathy and alcoholism (9, 10).

An increased prevalence of hysteria is seen in the first-degree female relatives of male sociopaths; first-degree male relatives of men with sociopathy show an increased prevalence of sociopathy and alcoholism (11).

There appears to be a pattern of assortative mating between hysterical women and sociopathic men. Sociopathy is increased in husbands of hysterical women and hysteria is increased in the wives of sociopathic men (10, 12).

Sociopathy and hysteria are found in the same women more often than would be expected by chance (13). An early delinquent and antisocial history frequently precedes the manifestations of hysteria (13). Sociopathy in fathers appears to be particularly associated with the development of hysteria in delinquent and sociopathic girls (14).

Since hysteria is characteristically a disorder of women and is rarely seen in men, and since sociopathy is predominantly seen in men although it may occur in women, it has been suggested that, "depending upon the sex of the individual, the same etiologic and pathogenetic factors may lead to different, although sometimes overlapping clinical pictures" (13).

Recent work with hyperactive children, which was stimulated in part by the findings described above, may help clarify the development of both hysteria and sociopathy. Hyperactive children appear to carry an increased risk of delinquency and sociopathy (15). The results of two studies of the families of hyperactive children (16, 17) are of great interest here. Each of these studies found an increased prevalence of sociopathy in the fathers and of hysteria in the mothers of hyperactive children compared with parents of control children. Similar findings were not found in adoptive parents of hyperactive children (18).

A FORMULATION

Based upon these studies, the following formulation may be useful: Hysteria and sociopathy have a common familial origin, whether genetic, social, or both. The earliest manifestations of the adult disorders may take the form of the hyperactive child syndrome. As the child matures, various forms of delinquency and antisocial be-

[1]Sociopathy, or antisocial personality, is defined as a disorder beginning early in life (before the age of 15) and manifested by recurrent antisocial, delinquent, and criminal behavior, including school troubles (e.g., truancy, fighting with teachers, suspension, expulsion), excessive fighting in general, running away, periods of wanderlust, poor job record (e.g., fired, quit without other job available, no sustained job), poor marital record, poor military record, history of alcohol and/or drug abuse, and trouble with the police.

havior may become evident. The clinical picture in adolescence and adulthood will depend in part on the sex of the individual. Briquet's syndrome will predominate in females and the sociopathic constellation will predominate in males.

Although the importance of the family in the pathogenesis seems clear, how the familial origin leads to the specific clinical disorders is not known. The possible interactions among parent-child relationships, socioeconomic status, and neurobiological factors remain to be clarified. The significance of the hyperactive child syndrome is also still obscure. Its presence may indicate some difficulty in central nervous system development or maturation.

Finally, the evidence pointing to an association between sociopathy and hysteria indicates that the research methods used in the studies described above—complementary follow-up and family studies—can produce data useful in studying etiology as well as in validating diagnostic classifications.

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Workshop on Writing for Scientific Journals

The 1975 annual meeting of the American Psychiatric Association will feature the second annual workshop on writing for scientific journals, to be held from 9 a.m. to 5 p.m. on Sunday, May 4 (the day before the annual meeting begins). The workshop, cosponsored by APA and the American Medical Writers Association (AMWA), will offer practical information and instruction on four subjects: common writing faults, organizing medical reports, getting your words on paper, and submitting a manuscript. Work assignments, which will be sent to registrants before the meeting, will form the basis for initial discussions during the workshop sessions. The course will begin with brief introductory lectures by the AMWA faculty, who include Charles G. Roland, M.D., chairman of the Department of Biomedical Communications, the Mayo Foundation; Barbara G. Cox, medical writer, Instructional Development Section, the Mayo Foundation; and Martha Tacker, Ph.D., free-lance medical writer and editor. Following the lectures there will be small-group discussions on the four basic subjects. The workshop will conclude with a panel discussion in which participants will have the opportunity to question the editors of several psychiatric journals.

Registration is limited to 40 participants. All applications for participation must be received by April 7; the registration fee is $65. For further information on registration write to Charles G. Roland, M.D., Department of Biomedical Communications, the Mayo Foundation, Rochester, Minn. 55901.

The Treatment of Adopted Versus Neglected Delinquent Children in the Court: A Problem of Reciprocal Attachment?

BY DOROTHY OTNOW LEWIS, M.D., DAVID BALLA, PH.D., MELVIN LEWIS, D.C.H., AND ROBERT GORE

The authors investigated the discrepant treatment by a juvenile court of adopted versus neglected delinquents. Adopted delinquents received harsher dispositions in spite of the fact that neglected delinquents often faced more serious charges. The two groups are compared in terms of family structure and the criminal and psychiatric histories of their parents; none of these seems to account for the adoptees' harsher treatment. The authors hypothesize that an interplay of late adoption, intrinsic vulnerabilities in the children, and weakness of parental bonds accounts for the differential outcomes.

THE PURPOSE OF this study was to investigate the apparently discrepant handling by the juvenile court of adopted versus neglected delinquent children and to explore several possible hypotheses that might account for this differential treatment.

Seven of the 262 children (2.5 percent) referred to a psychiatric clinic at the Juvenile Court of the Second District of Connecticut over a two-year period were adopted (the incidence of adopted children in the general population is less than 1 percent [1]). The parents of these 7 adopted children were extraordinarily rejecting toward them by the time they reached the juvenile court.

During the same period of time, we saw 26 allegedly neglected children who were referred to the clinic. Contrary to our expectations, their parents seemed to be extremely attached to and protective of them. These neglected children seemed to be especially prone to multiple and serious delinquent acts, but they received what appeared to be particularly gentle treatment from the juvenile justice system. We felt that the adopted children, who had less serious histories of delinquency, received far harsher treatment. This paper represents a systematic investigation of these clinical impressions.

Drs. Dorothy and Melvin Lewis and Dr. Balla are with the Child Study Center, Yale University, 333 Cedar St., New Haven, Conn. 06510, where Dr. Dorothy Lewis is Assistant Clinical Professor of Psychiatry, Dr. Balla is Research Associate, and Dr. Melvin Lewis is Professor of Clinical Pediatrics and Psychiatry. Mr. Gore was an undergraduate at Yale University at the time this work was done.

This work was supported by grant A70-9001-108 from the Connecticut Planning Committee on Criminal Administration and the Law Enforcement Assistance Administration.

METHOD

Our subjects were the 7 adopted and 26 neglected children referred to the juvenile court clinic during a two-year period. We gathered the following data for each group: type of disposition made by the court, number and severity of delinquency offenses, court clinic diagnosis, delinquency history of siblings, criminal and psychiatric treatment history of parents, family intactness, and age at adoption (where applicable). Severity of offenses was coded on a 3-point scale (1 = acts not criminal by adult standards, 2 = offenses against property, and 3 = offenses against person). In all comparisons of the two groups on these variables using chi-square analysis, Yates's correction for discontinuity was applied. Our clinical observation of the children and their families augmented these statistical data.

RESULTS

Our impression that the adopted children received harsher treatment in the court than the neglected children was confirmed. Only 1 of the 26 children in the neglected group (3 percent) was placed in a correctional institution (the most severe disposition available to the juvenile court), while 3 of the 7 adopted children (41 percent) received this disposition. The difference between these proportions is significant ($\chi^2 = 4.64$, $p < .05$). In addition, 3 of the 4 remaining adopted children received dispositions that removed them from their homes, and application was made for the 7th child to move into a residential placement. Few of the neglected children were ultimately removed from their homes.

This difference in dispositions may have been due to a variety of factors unrelated to adoptive status per se. For example, children in the adopted group might actually have committed more delinquent acts or more serious ones than children in the neglected group. We therefore compared the number and seriousness of offenses for the two groups, and found no differences between them in either variable. The adopted children committed an average of 8.71 delinquent acts, compared with an average of 9.27 for the neglected group ($t = .74$).

It was also important to determine whether the two groups of children displayed different degrees of

delinquent behavior, which could account for the differing dispositions they received. In the case of both type 1 (childhood offenses) and type 2 (property offenses), no significant differences were found. However, while there were no acts of violence (type 3 offenses) committed by adopted delinquents, 4 of the 26 neglected children committed such offenses. Although these numbers are not amenable to ordinary statistical treatment, the fact that 15 percent of the neglected children committed violent acts is noteworthy for two reasons. First, the adopted group received harsher treatment, despite the fact that they committed no violent acts. Second, neglected delinquent children would seem to be an especially important target population for efforts directed toward the prevention of violent and aggressive behavior.

The adopted children may have been given harsher dispositions in response to particularly disruptive behavior arising from their more disturbed psychological state. We found the severity of psychiatric impairment in the two groups to be similar, based on criteria reported in an earlier article (2): 2 of the 7 adopted children and 5 of the 26 neglected children demonstrated psychotic symptoms, proportions that are not significantly different ($\chi^2=0$).

Another possible explanation for the court's discrepant treatment of the two groups would be that adopted children's siblings were also delinquent, which would make removal from the home to an institution appear to be in the child's best interest. However, this was not the case. Not one of the 9 siblings of adopted children was known to the juvenile court, but 38 of the 82 siblings of neglected children had delinquency records, a significant difference ($\chi^2=5.38$, $p<.05$). (The biological relationship of the siblings in both groups was unknown in many cases.)

The decision to remove children from their homes could have been related to parental criminality or parental psychiatric disorders. This was not the case, as no adopted child had a parent with a criminal history, while 13 of the 26 neglected children came from families in which there were criminal records, a statistically significant difference ($\chi^2=3.87$, $p<.05$). Thus, having a criminal parent did not predispose the neglected child to placement in a correctional facility. We also found that 2 of 12 adoptive parents and 12 of 46 neglecting parents whose names and birthdates were known had been treated at state psychiatric facilities. The difference between these proportions was not statistically significant.

We wondered if children from nonintact families would be more likely to be sent to correctional institutions because of their parents' inability to act cohesively on their behalf. We found, however, that a significantly greater proportion of neglecting familes (18 of 26) than of adoptive families (1 in 7) were not intact ($\chi^2=4.75$, $p<.05$).

The difference in dispositions could not be explained in terms of conventional factors related to race or social class. All of the adoptive parents were white, whereas approximately one-third of the parents of the neglected children were black. The majority of adoptive parents were middle-class, while most of the neglected children came from lower-class backgrounds.

It would seem that the differences in dispositions were not accounted for by differences in delinquent behavior or by criminal, psychiatric, or socioeconomic factors in either the children or their parents.

The final factor we investigated was age at adoption. At least 5 of the 7 adoptions took place after infancy: 3 children were adopted at approximately two years of age (1 of the 3 was then given up and adopted again later), 1 child was adopted at age three, and 1 child was five years old at the time of adoption.

DISCUSSION

Our findings led us to conclude that some factor that was not amenable to quantitative analysis was operating in this situation. We felt that this factor was probably peculiar to adoption. It seemed that reciprocal attachment between parent and child, which is considered crucial to normal adaptation, was not strong enough under certain circumstances of adoption to resist the stresses of a particularly difficult adolescence.

It would be inaccurate to assume that the adoptive parents of delinquents had always rejected their children, since 5 of the 7 sets of parents had sought psychological assistance for their children prior to court referral. Two families had gone to child guidance clinics, two to private therapists, and one couple had obtained private psychiatric hospitalization and special schooling for their child. Many of these families had participated in lengthy therapeutic endeavors. In spite of this, by the time the adoptive family reached the juvenile court, the parents were blatantly rejecting toward their children. Two families had even hired lawyers in attempts to nullify long-standing adoptions. This contrasts with the behavior of most parents involved with the court (including neglecting parents), who ordinarily use lawyers to defend their parental rights. Two other adoptive parents refused to come to the court clinic to assist in therapeutic dispositions, despite the fact that their children were seriously disturbed and required psychiatric intervention. A few adoptive parents requested placement for their children in correctional institutions.

The adopted delinquent indeed did not have a friend in court. One basic function of a parent in the juvenile court is to defend and protect his child's interests. The so-called neglecting parents, by and large, mustered their forces to perform this crucial function. Although these children were often physically and psychologically neglected because of home lives that were generally chaotic, the conscious attitude of their parents was not neglectful or hostile.

Exploration of causality in the ultimate disintegration of the bond between parents and adopted delinquents leads to consideration of some very difficult issues in parent-child relationships. These issues involve the relative contributions of intrinsic vulnerabilities, experiential factors, and unconscious fantasies. It is too simplistic to conclude that either the parents' malignant attitudes or a child's particular problems alone determined the unfortu-

nate outcome of these cases. Rather, it seems that a combination of factors, including age at adoption, contributed to the ultimate fracture of family bonds.

Intrinsic Vulnerabilities

There is ample evidence from retrospective studies that adopted children are more prone to psychiatric problems than the general population. Mikawa and Boston (3) reported that although less than 1 percent of all live births result in adoption, the percentage of adoptees known to three California psychiatric institutions over a five-year period ranged from 4 percent up to 9.6 percent. Toussieng (4) noted that 10.9 percent of all children seen at the Menninger Clinic over a five-year period were adopted, and Schecter (5) reported that 13 percent of his patients in private practice were adopted. The incidence of adopted children referred to the court clinic (2.5 percent) also exceeds the incidence in the general population. The reasons for this overrepresentation are complex.

The question of whether intrinsic vulnerabilities of adopted children account for subsequent emotional disturbances remains controversial. Rosenthal and associates (6) examined the genetic and environmental factors contributing to the development of schizophrenia in groups of adopted children. They documented the greater likelihood of schizophrenia developing both in the biological children of schizophrenics adopted into nonschizophrenic families and in children of nonschizophrenic parents who were adopted into schizophrenic homes. Scott (7) reported Mednick's finding that there was a greater association between the criminality of biological fathers and their adopted-away sons than between adoptees and their adoptive fathers.

These findings, although accepted by some, have been questioned. Bohman's findings in a follow-up study of adoptees (8) suggested that "psychological or social insufficiency in the biological mothers was not reflected at all in maladjustment among the children" (p. 218). In addition, he found no relationship between criminality in biological fathers of adoptees and the subsequent adjustment of a child in an adoptive home.

Parental Attitudes and Characteristics

There is some evidence that parental attitudes and characteristics are crucial factors in the adjustment of adopted children. Lawder and associates (9) noted that when parents are critical of their adopted children for any reason during the supervisory adoption period, later parent-child adjustment tends to be less successful than it is when parents are pleased during the first months. Bohman (8) has also cited the personal characteristics of adoptive parents as very significant factors in the child's future adjustment. Mikawa and Boston (3) found that although there was a greater incidence of emotional disturbance in adopted children than in biological offspring, this more often resulted from parent-child interactional difficulties than from problems specifically related to adoption.

Pemberton and Benady (10) described 12 cases in which pathological interaction between children and parents eventually led to removal of the child. In these families, the rejected child was particularly aggressive and negativistic toward his parents, and the parents had unstable marriages. These children (only one of whom was adopted) also manifested more lying, stealing, enuresis, and encopresis than a comparison group. It is not clear from Pemberton and Benady's study, however, whether the child was rejected because he was intrinsically more difficult to control than other children in the home or whether the child's negativistic behavior was a response to early parental rejection.

Since there were similar antisocial behaviors and degrees of pathology in the neglected and adopted children in our study, one must ask what other factors might have contributed to the formation of tenuous parent-child attachments in the adopted children. There is evidence that parents tend to form less than optimal attachments to children they perceive to be less than perfect in several areas. The infant is normally a determinant of some of the mother's behavior (11). For example, eye contact seems to foster positive maternal feelings (12), and certain types of early behavior (e.g., crying, following, clinging, and sucking) appear to act as "releasers," stimulating instinctual responses in the mother (13). However, when the child has a defect (blindness, for example), the parents may experience unconscious revulsion toward the child that is manifested as severe avoidance (14). Kanner (15) attributed the autistic behavior of infants to cold, unresponsive mothers; since his work was done, the child's contribution to the mother's unresponsiveness has been increasingly emphasized (16).

Because all of the studies we have described in this section highlight interactional factors leading to parent-child difficulties, they encouraged us to search for possible analogous, if not identical, factors operating in the parent-child relationships of adopted delinquents. Several of the adopted delinquents had arrived at their new homes with a variety of physical and emotional problems. Two were covered with unsightly sores and one, adopted at eight days of age, was recovering from head surgery of an undetermined nature when he arrived at his adoptive home. One child had been sexually assaulted several times prior to adoption. However, parents of neglected children with comparable physical and emotional problems were possessive of them.

Age at Adoption

Another factor that was probably significant was the lateness of adoption: 5 of the 7 children were adopted after their second year. According to Yarrow (17), children placed in adoptive homes when they are younger than six months demonstrate fewer atypical behaviors than those adopted after that age. Casler (18) noted the extremely deleterious emotional effects of placement between six months and one year of age. Bowlby (13) and Spitz and Wolff (19) found emotional difficulties subsequent to the disruption of an ongoing relationship during critical periods of infant development. Lawder and associates (9), however, did not find an association between later placement and poor outcome of adoption. Furthermore,

Kadushin (20) cited numerous studies documenting the resiliency of children and the possibility of reversing the effects of early emotional deprivation.

CONCLUSIONS

We believe that neither acquired nor intrinsic defects alone caused the extreme rejection of the adopted children by their parents; nor was the factor of late adoption alone sufficient to fracture the parent-child bond. Rather, it is likely that late adoption coupled with perceived (and often real) defects in the children prevented parental attachment from becoming strong enough to weather the stresses of disruptive adolescent behavior. These older and often perceptibly damaged youngsters could not evoke the intense parental response necessary to forge an indissoluble bond between parent and child. Paradoxically, most of the adopted children were intensely attached to their parents and were therefore significantly affected by the rejection.

Our findings have practical implications for dealing with adopted delinquents in court. The evidence that adopted delinquents lack a friend in court makes it incumbent on probation and judicial personnel to be alert to their special problems and to ensure that they are provided with an understanding advocate to defend their interests. The question remains whether any court-appointed individual can approximate or substitute for the intense advocacy of a parent.

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Prevention in Mental Health: A Controlled Study

BY PAUL R. POLAK, M.D., DONALD EGAN, M.D., RICHARD VANDENBERGH, M.D., AND W. VAIL WILLIAMS, PH.D.

The authors conducted a controlled study in which families who had experienced the sudden death of a family member were given crisis intervention services and compared at follow-up with two untreated control groups. Results did not support the hypothesis that such services decrease the risk of psychiatric illness, disturbed family functioning, or increased social cost to the families. The authors suggest that environmental and social systems factors and individual variables are powerful predictors of outcome in bereavement.

CRISIS STATES have often been pinpointed as opportune points of focus for preventive mental health programs (1). Rees and Lutkins (2) and others (3) have found a significant increase in the risk of morbidity and mortality within the first year after the death of a family member. To test the hypothesis that preventive crisis intervention would decrease the risk of incidence of psychiatric illness, physical illness, and social disturbance, such services were provided to 39 families after a sudden death.

METHOD

Crisis Intervention

Treatment began when intervention team members accompanied the medical examiner of the Denver County coroner's office to the homes of the surviving members, usually within 1 to 2 hours after the death. The first meeting with the family lasted from 1 to 6 hours; intervention techniques varied from arranging supervision for children to assisting in notifying relatives and helping families to work through their grief.

Families were seen for 2 to 6 sessions over a period of 1 to 10 weeks, and crisis intervention techniques were used within a social systems framework (4). Treatment focused on increasing the effectiveness of the family in coping with feelings, decisions, and problems of adjustment related to death (5). Intervention took place within the boundaries and values of the social system in its natural setting rather than following a formal psychotherapeutic format. Therapeutic telephone interactions were employed regularly and frequently.

Experimental Design

The research design involved three subject groups: an experimental group of 39 families who received crisis intervention following a recent sudden death, a control group of 66 families who received no crisis intervention following a recent sudden death, and another control group of 56 families who had experienced no death within 2 years prior to contact and who received no crisis intervention.[1]

Families who experienced a recent sudden death were randomly assigned to the experimental (treated) group or to the control (untreated) group. All groups (including the nonbereaved control group) were matched for age, socioeconomic status, education, and residential location.

Outcome Measures

Outcome measures were collected at 6 and 18 months after the death by an independent research team that used three data collection techniques. Self-report questionnaires were related to: 1) physical illness, measured by the Cornell Medical Index (6); 2) psychiatric illness, measured by the Minnesota Multiphasic Personality Inventory, the Stirling County questionnaire (7), Beck's depression scale (8), and questions adapted from the Boston bereavement project (3); 3) family functioning, measured by the Ferriera and Winter unrevealed differences technique (9) and the Bodin free-drawing technique (10); 4) crisis coping, measured by a questionnaire developed by project staff to obtain stress levels specific to bereavement adjustment problems; and 5) intellectual functioning, measured by Harvey's Conceptual Systems Test (11). Evaluation ratings involved interviews with family members on such matters as overall family functioning, depression, physical and mental health (based on direct interviews with family members conducted by a psychiatrist), and socioeconomic and social well-being. Social cost questionnaires examined pre/post income, expenses, indirect costs, and/or losses. All the raw data

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[1]Both control groups were free to make use of psychiatric help outside the project, and, in fact, a very small proportion of families in both control groups sought psychiatric help.

collected soon after the death and at the 6-month interval were subjected to a principal components factor analysis; the 13 stable outcome factors that were identified are listed in appendix 1.

RESULTS

The results of the 18-month data collection will not be reported in this paper. Our discussion of the 6-month data analysis involves three areas: 1) 6-month outcome data evaluating the efficacy of crisis intervention as a preventive technique for families experiencing acute bereavement; 2) the effects of the crisis of sudden death on subsequent physical, mental, and social functioning by comparing the outcome of families who experienced a sudden death with those who did not; and 3) our clinical observations on the interaction among environmental, social systems, and individual variables.

Efficacy of Crisis Intervention

Data analysis of the sampling characteristics of the treated and untreated bereaved groups revealed more suicidal deaths ($F=5.1$, $p<.025$) and a higher degree of suddenness of death ($F=9.8$, $p<.002$) in the treated group. It appears that the deputy coroner unwittingly selected a greater proportion of families in which the death was suicidal or accidental (and therefore more sudden) for clinical intervention by the project staff. Initial analysis of the data suggests that the treated group had poorer outcomes than the untreated group. However, when the proportion of accidental and suicidal deaths was held constant in an analysis of covariance, the differences between these two groups disappeared; i.e., 6 months after the death there were no major statistically significant differences between the bereaved families who received treatment and those who did not. The untreated bereaved group did, however, exhibit significantly less concern than the treated group over their socioeconomic and social well-being 6 months after the death ($p<.004$).

In summary, the 6-month outcome data analysis suggests that the crisis prevention program did not improve coping behavior or lower the incidence of medical and psychiatric illness or of disturbed social functioning in bereaved families.

Comparison of Bereaved and Nonbereaved Families

Preliminary data analysis on the sampling characteristics of the bereaved and nonbereaved groups revealed that the nonbereaved group had a better social and personal adjustment prior to participation in this project ($F=60.2$, $p<.001$) than the death-related groups. We therefore utilized an analysis of covariance on the 6-month outcome data for the factors listed in appendix 1 in order to make the bereaved and nonbereaved groups more comparable. Our results indicated that 6 months after a death family members in both bereaved groups showed poorer functioning in several areas than nonbereaved families—both groups of bereaved families had significantly greater acting out (pathological emotional expression)[2] ($p<.05$), greater depression ($p<.001$), and greater problems in family, intrapersonal, interpersonal, and social functioning (crisis coping) ($p<.05$).

Clinical Observations

The sudden death of a family member appeared to have a far-reaching impact on the survivors; however, short-term crisis intervention aimed at strengthening interpersonal and intrapsychic adaptation to the death apparently did not. Some of our observations on the interaction among environmental, social systems, and individual variables may lay the groundwork for an initial interpretation of this challenging finding.

Death as an environmental stimulus. There seemed to be a high correlation between poor outcome (measured by the development of physical or mental illness or serious social disruption in the family) and the following tragic circumstances: 1) degree of suddenness, 2) degree of violence, 3) direct observation of the death and the occurrence of the death in the home, 4) suicidal death, 5) death of a child under 12, and 6) family members directly or indirectly contributing to the death. On the other hand, when there had been heavy burdens on the family resulting from a family member's chronic debilitating illness or chronic economic and social burdens (such as those imposed on a family by a socially disruptive, chronically ill alcoholic), death seemed to alleviate stress, and the adjustment of family members to the death was less difficult.

Social systems factors. It is our impression that in cases of sudden death a family must be able to carry out a number of organizational tasks in order to adjust to the death. One of the most important of these tasks is role reallocation. To accomplish this, family members must first be able to realistically appraise the roles the decedent had played in family life and to define which of these roles could be assumed by surviving family members; then, the roles must be reallocated within the reconstituted family group at an appropriate time. These roles include not only instrumental roles such as breadwinner and disciplinarian but also expressive roles such as communications facilitator and mediator.

In view of the complexity of role reallocation and other organizational tasks after the death, the familial characteristics that were associated with good outcome are not surprising. For example, families with a high degree of effective communication and flexibility or those who had previously exhibited a high degree of problem-solving capacity tended not to develop physical or mental illness or disturbed social functioning. Outcome was also favorable in families who could call on an effective network of formal and informal social resources outside the family.

[2]There was a significant family main effect ($F=11.9$, $p<.001$)—the younger the individual, the more acting out. There was no significant family × death interaction.

The families who lacked these positive characteristics tended to experience poor outcome.

Special roles played by the decedent prior to his death also tended to be predictive of outcome. For instance, when the decedent had played an expressive role (such as scapegoat, delinquent, or mental patient) that communicated about an ongoing family conflict and at the same time served to keep the conflict in balance, his death often resulted in mental and physical illness and social disruption for family members. The negative effects were magnified when the circumstances of the death itself served to intensify and potentiate the unresolved family conflict.

Certain religious convictions tended to promote externalization. Family members who belonged to fundamentalist religious groups had incorporated highly structured explanations of the causes of death and of man's fate after death. Family members attributed the death to God's will and refused to discuss any facet of their realistic involvement in the death or to elaborate on specific grief reactions. These families would be considered in psychiatric terms to be using denial quite extensively and, at times, pathologically. Yet up to two years after the death they appeared to maintain good physical and mental health ratings and appeared to be benefiting from this defense.

Individual factors. Preliminary data suggest that the individual's degree of unexpressed feelings of hopelessness and despair, combined with his crisis-coping ability and tendency to discharge emotional conflicts through somatic dysfunction rather than behavioral dysfunction, were predictive of the development of serious physical and emotional illnesses. These results support the findings of previous retrospective studies (12–14).

From the interview data, it is our impression that other variables are also predictive of subsequent serious illness. Individuals who are able to maintain a healthy level of denial have a better outcome, and the predictive value of individual variables is enhanced when they are considered in combination with environmental, family, and social systems variables.

Interaction of environmental, social systems, and individual factors. Perhaps our most important observation was the crucial interaction among environmental, social systems, and individual variables in determining outcome. A review of our case notes indicated that among families rated comparable on social systems variables, those who experienced deaths under conditions of greater environmental stress showed a poorer bereavement outcome. Similarly, when environmental factors seemed comparable, the family with negative social systems patterns tended to experience poorer outcome. Finally, in those instances when the environmental factors, social systems factors, and individual characteristics were all predisposed toward poor outcome, the risk of illness and social disturbance was very high.

Conversely, it often seemed that the effects of particularly negative environmental variables around a death could be counteracted by a flexible family system with impressive communication and problem-solving skills; the same tragic circumstances occurring in a fragmented, uncommunicative family would lead to poor physical and mental health after the death.

CONCLUSIONS

Our results did not support the hypothesis that a preventive crisis intervention service would decrease the risk of psychiatric illness, disturbed family functioning, and increased social cost for families experiencing acute bereavement. (This finding does not imply that crisis intervention is ineffective as a preventive technique in other crisis situations.) At the same time, families in which there had been a more sudden death showed much greater evidence of mental illness and other negative outcome factors six months after the death.

These data and our clinical observations suggest that environmental forces play a much greater role in determining outcome than is often believed. Social systems factors also seem to be important intervening variables in influencing outcome, but existing techniques of crisis intervention are not effective in producing significant constructive social systems changes in situations such as sudden death. It is hoped that continued study will clarify the interaction among environmental, individual, and social variables and lead to more effective techniques of preventive intervention.

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APPENDIX 1
Thirteen Outcome Factors

1. Anxiety
2. Family unity
3. Acting out (pathological emotional expression)
4. Crisis coping
5. Need for people
6. Family decision making
7. Health
8. Family general functioning
9. Concerns (socioeconomic and social well-being)
10. Depression
11. Income (monthly)
12. Living expenses (monthly)
13. Economic losses and costs

Prompt Publication Policy

The *Journal* would like to remind those authors who are particularly interested in early publication (whether to establish priority of an idea, reveal innovative results of new research, or for other pressing reasons) of its prompt publication policy, first announced in the April 1971 issue (p. 1399) as follows:

"The *Journal* would consider publishing very short (two- to four-page) manuscripts in the first available issue. Of course, these manuscripts will still have to undergo expert scrutiny before being accepted, and two months must be allowed for the printing process, but we think we can considerably shorten the time required for the publication of these very short articles, which will be included in the Brief Communications section."

Authors who would like to have their manuscripts considered under this policy should indicate this desire, as well as the reasons for it, when they submit their manuscripts.



Suicide in the Psychiatric Hospital

BY DONALD A. SCHWARTZ, M.D., DON E. FLINN, M.D., AND PAUL F. SLAWSON, M.D.

The authors note that although the psychiatric hospital is often used as a means of preventing the suicide of disturbed patients, some hospitalized patients succeed in committing suicide; such an event is distressing for hospital staffs as well as for patients and families. However, the authors believe that the occasional occurrence of in-hospital suicide is inevitable. They present data on the frequency and characteristics of suicides among hospitalized psychiatric patients in Los Angeles County during the period from 1967 to 1972.

IT MAY SEEM difficult to understand how a patient could commit suicide in a psychiatric hospital. As the wife of one patient said when she was told he had done so, "But that was why we sent him there." Nevertheless, in our view there is no way that one can prevent a person intent on suicide from completion of the act. That so many "suicidal" persons are deterred testifies more to their ambivalence than to the capacity of others to prevent suicide. Not hospitalization, one-to-one surveillance, seclusion, or physical restraints will prevent suicide if the patient is determined to commit it.

The frequency of suicides in psychiatric hospitals is not well known. Most articles on the subject are based on data from a particular hospital or hospital system. Farberow and associates (1, 2) derived a great deal of data from Veterans Administration hospitals. (Their work dealt with suicides in general medical and surgical hospitals as well as in neuropsychiatric hospitals.) Sletten and coworkers (3) reported on suicides in the Missouri state mental hospital system, and Kirven (4) presented data on suicides in the Virginia state mental hospital system. Several other reports (5–8) dealt with the experience at individual hospitals. Temoche and associates (9) reviewed all suicides in Massachusetts for a three-year period (1949 to 1951). They wished to compare the suicide sample with the general population, but because the data on the general population available to them covered only the white population, they excluded data on nonwhite suicides from their report. None of these studies reported on the total hospital population of a geographic area in the United States.

Two Scandinavian authors provided data on mental hospital suicide incidence in total populations. Ødegård (10) reported on mortality in general in Norwegian mental hospitals during the years 1926 to 1941. Among the causes of death, he separated out a group of "unnatural deaths," the majority of which were suicides. Definite suicides were reported as one subgroup and other unnatural deaths as another; some of the latter group were probably unproved suicides. Achté and coworkers (11) reported on suicides committed in psychiatric hospitals in the mental health district of Helsinki, Finland. Their study, covering the years 1952 to 1963, is the most recent total area study of suicide in mental hospitals.

SCOPE OF PRESENT STUDY

We were curious to know how often patients completed suicide in hospitals in our own area and what the characteristics of such patients were. Since suicide is a sensitive topic, we anticipated a reluctance of hospital staff to reveal pertinent data; therefore, we decided to use an anonymous questionnaire rather than an identified inquiry. But that raised the question of failures to respond. Confidence in the data would depend on securing the largest possible percentage response. For this reason, we began our study by telephoning the chiefs of staff, administrators, or medical directors of all hospitals with psychiatric beds in Los Angeles County to tell them about the study and to solicit their cooperation. The contacts were made, whenever possible, by one of us who knew the person being approached. The questionnaire was mailed to the hospital only after we had secured the cooperation of the potential respondent and answered any questions. In all cases the questionnaire was addressed to the person who had agreed to be responsible for its completion.

No one refused to participate or showed overt reluctance. However, in spite of this apparent cooperative spirit, 6 of the 33 hospitals to which questionnaires were sent did not return them, even after a follow-up letter. Some hospitals returned the questionnaire only after personal follow-up contacts. (This was possible in spite of the anonymity of response because some of the hospitals

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were unique in size and type of sponsorship and thus were inevitably identifiable.) Although we had originally wanted to survey a larger area than Los Angeles County, we limited the study to that region in order to increase the probability that one of us would have sufficient personal relationships with the staff of each hospital, thus increasing the likelihood of a response. Because our return rate was only 80 percent in spite of all these efforts, we concluded that our limitation of the geographic scope of the study was wise.

METHOD

Each psychiatric hospital and each general hospital in Los Angeles County with a psychiatric inpatient unit was included if the facility had been in operation for at least one year. Each was asked to fill out a sheet indicating whether any patients had committed suicide while they were carried on the hospital books during the period of January 1, 1967, to May 1, 1972. If so, we asked how many such suicides had occurred in the hospital, how many on authorized leave, and how many on unauthorized leave. Certain basic information concerning the facility was asked for, particularly its sponsorship and general size. Further details were not requested because we wished to ensure the anonymity of the data and thereby increase the percentage of response.

In addition to this information we requested that a case report be filled out on each case of suicide (up to five cases), giving a variety of information about the person and the circumstances of his or her illness and suicide. We asked for age, sex, marital status, occupation, diagnosis, and acuteness or chronicity of the illness for which he or she had been hospitalized. We asked where the suicide occurred, by what method, how well it was investigated, whether it might have been prevented, whether any changes in policy were made afterward, and whether litigation over the suicide had occurred.

RESULTS

Los Angeles County had 33 hospitals that met all of our criteria. Of these, 2 were state hospitals, 3 were VA hospitals, 3 were county hospitals, 14 were nonprofit private hospitals (some of them forming parts of community mental health centers), and 11 were proprietary hospitals. Of the 33 hospitals, 27 returned the questionnaires; these 27 included all of the public facilities. Four of the 14 private nonprofit hospitals and 2 of the 11 proprietary hospitals failed to return their questionnaires. Based on the hospitals returning questionnaires, the bulk of the suicides occurred in public hospitals. If the 6 nonresponding private hospitals were typical of the entire private sector, their failures to respond would not greatly affect the conclusions of the study. However, it is possible that these 6 hospitals failed to respond precisely because they did not want to reveal high rates of completed suicide and did not trust the anonymity of the study.

Of the responding hospitals, 3 had censuses over 200, 9 had censuses between 50 and 200, and 15 had censuses below 50. The hospital census data obtained from the Mental Health Division of the Los Angeles County Department of Health Services indicated that 4 of the nonresponding hospitals would have had censuses between 50 and 200 beds and that 2 would have had censuses below 50 beds.

Of the 27 hospitals responding, 14 had had at least one suicide during the study period and 13 had had none. The 13 hospitals with no suicides were 1 county, 6 private nonprofit, and 6 proprietary facilities. There had been a total of 49 suicides in all responding facilities, 26 of which had been committed in the hospital, 14 while the patient was on authorized leave, and 9 during unauthorized absences.

When we planned the study, we had no idea how many patients might have committed suicide in any one hospital. We were concerned that a hospital which had many suicides might fail to respond if asked to fill out a two-page report on each case—simply because of the work involved. To avoid such a possibility, we asked for case reports on only the last 5 cases. As it turned out, the largest number of cases in any one hospital was 8; two hospitals reported more than 5 cases—one VA hospital reported 6 and one state hospital reported 7. Of the total of 49 cases, we received individual case reports on 45. The balance of the data to be reported in this paper relates to those 45 cases.

Of the 45 cases, 31 were men and 14 were women. The median age was 37 years, with a range from 19 to 88 years; 28 (62 percent) were between 25 and 49 years old. We obtained marital status information on 44 cases—12 were single, 25 were married, 6 were divorced, and 1 was separated. According to our occupational data, 5 patients were in artistic or professional occupations, 1 in a technical field, 4 in managerial positions, 6 in sales or clerical work, 3 were craftsmen, 2 were service workers, 2 were laborers, 9 were housewives, 6 were students, and 7 were in unknown occupations or unemployed (including a few veteran patients whose only known occupation had been their military service).

Diagnostic data revealed a variety of diagnoses, with the majority falling into the schizophrenias and the affective disorders. The precise breakdown is shown in table 1. Thirteen of the patients were judged to be acutely ill, 27 chronically ill, and 5 were reported to be both acutely and chronically ill.

Of the 45 patients on whom individual reports were obtained, 23 had committed suicide in the hospital, 13 on authorized leave, and 9 on unauthorized leave. Of those who suicided in the hospital, 15 had been on a locked ward, 7 on an unlocked ward, and 1 in a private room. Of the in-hospital suicides, 6 had been on suicidal or special observation and 14 had not; in 3 cases, there was no response to this question.

Reports of method of suicide showed the usual preponderance of hanging that has been reported in every hospital suicide study we have seen in the literature. Hanging was the mode of suicide in 17 of the 45 cases,

TABLE 1
Type and Frequency of Diagnosis

Diagnosis	Number (N=45)
Schizophrenia	17
Paranoid	7
Schizo-affective	5
Acute	2
Chronic	3
Depression	20
Manic-depressive	2
Involutional melancholia	3
Psychotic depressive reaction	6
Neurotic depression	9
Other diagnoses	8
Acute psychosis	1
Postpartum psychosis	1
Obsessive-compulsive neurosis	1
Mixed neurosis	1
Alcoholic withdrawal	1
Hysterical personality	1
Antisocial personality	1
No psychiatric diagnosis	1

TABLE 2
Method of Suicide

Method	Women (N=14)	Men (N=31)	Total (N=45)
Hanging	6	11	17
Strangulation (other than by hanging)	1	3	4
Suffocation (other than by strangulation)	0	2	2
Gunshot	2	5	7
Jumping	2	4	6
Drug overdose	0	3	3
Automobile	2	0	2
Stabbing	0	1	1
Drowning	0	1	1
Unknown	1	1	2

TABLE 3
Acuteness and/or Chronicity as Related to Broad Diagnostic Groupings

Diagnostic Group	Acute* (N=13)	Chronic (N=27)	Acute and Chronic (N=5)	Total (N=45)
Schizophrenias	8	9	0	17
Depressions	1	15	4	20
Other diagnoses	4	3	1	8

*Significantly different among the three diagnostic groups (p=.02, chi-square analysis).

with a wide dispersion of other modes (see table 2).

Thorough or exhaustive investigations of the suicide were made in 30 of the 45 cases, and cursory or no investigations were made in the other 15. It might be assumed at first that the thoroughness of investigation would be largely correlated with location of the suicide (i.e., exhaustive for in-hospital suicides and cursory for those away from the hospital). In fact, however, the degree of investigation appeared to be hospital-related. The 15 cases with no investigation or a cursory one consisted of 8 of the 13 VA cases, 5 of the 8 private nonprofit cases, only 2 of the 12 state hospital cases, and none of the cases from county or proprietary hospitals. In contrast, the 30 thorough or exhaustive investigations consisted of 10 of the 12 state hospital cases, all of the 8 county hospital cases, all of the 4 proprietary hospital cases, only 5 of the 13 VA cases, and 3 of the 8 private nonprofit cases.

In 40 of the 45 cases, respondents made a judgment as to whether the suicide could have been prevented. In 9 of those 40 cases there was definite or strongly suggestive evidence for preventability, and in 31 cases there was either equivocal or no evidence. Interestingly, 8 of the 9 cases judged to have been potentially preventable were from state, county, or proprietary hospitals, i.e., those which had made more thorough investigations of the circumstances of suicide. Perhaps expectably, 8 of the 9 were in-hospital suicides.

The suicide resulted in litigation in 10 cases; 9 of the 10 entailed the filing of a lawsuit. Of the 10 cases, 6 had been settled for less than $100,000 each (without any of them going to trial) and 4 cases remained unsettled at the time of this study. We will be reporting the data on litigation in more detail in another paper.

When variables were cross-tabulated against each other, no significant correlations were found. Interestingly, choice of method did not correlate significantly with sex. VA patients suiciding outside the hospital often used firearms (as has been reported previously); 5 of the 7 gunshot cases were VA patients, 1 of whom was a woman. The 3 drug overdose cases involved men.

Diagnostic categories were then collapsed and a cross-tabulation was made of the broad categories against other variables. Diagnoses were classified as schizophrenias, affective disorders (psychotic and neurotic), and all others. This set of cross-tabulations showed one statistically significant finding—the relationship of acuteness or chronicity to collapsed diagnostic categories (see table 3). Only 1 case of affective disorder was classified as acute only, while almost half of the schizophrenic cases and half of the "other" cases were judged to be acute only. This difference was statistically significant (p=.02, chi-square analysis).

The median age was 29 in the schizophrenic group and 42 in the depressive group, with the other group intermediate, but the distributions were not significantly different.

DISCUSSION

Since our data are derived from questionnaire responses with only 80 percent return, we cannot draw any firm conclusions about rates of hospital suicide. Moreover, some cases may not have been reported because of simple forgetfulness since most hospitals did not have a

formal system for storing data on hospital suicides as a class. However, the fact that we have responses from 80 percent of the hospitals in a total county area covering hospital suicides for a period of five years and four months permits us to draw some tentative conclusions.

As a generalization, we can say that the frequency of hospital suicides is not very great. An 80 percent sample of all psychiatric facilities in Los Angeles County, with a total county population of 7.5 million, yielded fewer than 9 suicides a year. Almost half of these were patients on leave or unauthorized absence from the hospital. Suicides in psychiatric hospitals are generally reported to be most frequent in patients diagnosed as schizophrenic. However, most of the reports in the literature have been from large public hospitals, where schizophrenia is the most common diagnosis in the hospital population in general.

Our own study revealed only one-third of the cases with a schizophrenic diagnosis, but our data are derived from a wider range of inpatient facilities than is true of most studies. In the community in general, the preponderance of diagnosis is not as heavily schizophrenic as in the large public facilities. Our data show the usual preponderance of men over women that is reported in hospital and other suicide samples. We found much the usual distribution of methods for hospital suicides.

We wonder whether the relationship of chronicity to depressive suicides as contrasted with suicides of patients in schizophrenic and other diagnostic categories reflects something we have mentioned before (12), namely, that hospital staffs and patients alike tolerate intensive observation of the acutely suicidal patient for brief periods but that long continued close observation produces stress and evokes resentment. Suicides by schizophrenics are generally less predictable and preventable than those associated with depressive disorders for a variety of reasons. The acutely depressed patient generally gives warning of his suicidal preoccupation and may be deterred from the impulse by the protective responses of hospital staff members. However, the chronically depressed and suicidal patient may be reacted to as the "boy who cried wolf" and assumed to be a lesser risk than he really is. This is especially likely after long periods of suicidal preoccupation or threat, or after numbers of previous attempts.

We were struck by the unpredictability of most of these suicides. Although some cases were judged on the basis of investigation to have been potentially preventable, most were not, even when examined retrospectively. Most of the patients were not on suicidal or special observation at the time of their suicides, although many had been under such observation in the past. Thus staff who were aware of past suicidality were not impressed with the current lethal intent of the patients.

The fact that only 49 completed suicides of patients carried on the current census of psychiatric inpatient facilities can be identified over a period of five years and four months is also noteworthy in regard to the problem of prediction. This is a small number of completed suicides out of a very large potentially suicidal population. There are no crucial characteristics that differentiate those who will suicide from those who might but will not. The small number of completed suicides makes identification of such differentiating variables difficult.

In evaluating the worth of suicide prevention measures, we need to weigh the desirability of preventing actual suicides against the deleterious effects of stringent suicidal observation on all the patients to whom it might be applied. As has been pointed out before by us (12) and others (13), there are disabilities, some potentially fatal, that may result from "overprevention," and these must be considered. Finally, we do not believe a person who is absolutely intent on suicide can be deterred from it. It is fortunate for the cause of suicide prevention that such unambivalent suicidality is the exception to the rule.

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The Addict, Abstinence, and the Family

BY JOHN SCHWARTZMAN, PH.D.

The drug addict generally has an extremely difficult time terminating drug use and remaining abstinent. A partial explanation can be found in an investigation of the relative meaning of the drug for the addict within his social context rather than viewing the drug simply as a pharmacological agent. The idea that addiction is a social phenomenon within the addict's family suggests a relationship between the functioning of the families of addicts and their inability to tolerate abstinence. Because the abuse of heroin or barbiturates by one family member can result in "rewards" for all family members, the family, in behaving as if the addict cannot control his drug use, functions in such a way as to reinforce the addiction.

THERE IS GENERAL AGREEMENT in the literature on the structure of families of drug addicts and the effects of these families on the addiction of a family member (1). Most of the research on opiate addiction considers only the physiological effects of drugs and assumes that the structure of the family compounds the addict's physiological dependence because it reinforces his feeling of inadequacy and low self-esteem (2). However, if one assumes that the effects of any drug are modifiable by the context of drug use and by the characteristics of the user, a different explanation is suggested as to how the families of drug addicts function in relationship to the inability of addicts to tolerate abstinence.

This paper is based on an investigation of 21 predominantly white working-class families, each of which included at least one male heroin or barbiturate addict. These addicts were seen at an inpatient drug unit, an outpatient methadone clinic, and an outpatient mental health clinic. They ranged in age from 16 to 36, with an average age of about 23.

The familes were seen in from 1 to 22 one-hour psychotherapy sessions. Information was also collected in informal interviews with the addicts in these families and with other addicts.

My clinical impression was that there were no significant differences between the families of heroin addicts and the families of barbiturate addicts. Most of the heroin addicts used barbiturates occasionally, but very few of the barbiturate addicts ever used heroin. However, the barbiturate addicts were more likely to drink excessively.

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The description of these families of addicts suggests that therapy should be reoriented toward seeing the locus of the problem as among family members or other significant others rather than in the addict. Therapeutic intervention in the addict's relationships with his addicted peers and with his family thus seems more promising than the more prevalent mode of group therapy among drug addicts.

LITERATURE ON FAMILIES OF ADDICTS

Almost all descriptions in the literature indicate that the addict's[1] relationship to his mother is the most important one for him within the family (3–5). The mothers were found to be overprotecting, controlling, and indulgent toward their sons (1, 3, 4). Most authors agree that the addict is more intimate with his mother than with his father and that the addict becomes used to gratifying the mother's emotional needs (1, 3–5). The mother then unconsciously strives to delay the maturation of the addict by infantilizing him (1, 3). There is also evidence (6–8) that other members of families of addicts have high rates of alcoholism and mental illness.

Although most of the literature on the families of addicts is consistent, the composite description does not seem to explain the dynamics of how families of addicts function or what this type of family has to do with drug addiction in particular. The composite description is similar to descriptions of families containing members with a wide variety of psychiatric symptoms (9–11).

THE PHARMACOLOGICAL FALLACY

The literature on the relationship between the addict's family and his addiction describes how a particular type of family produces an inadequate, immature individual who is unable to tolerate abstinence. There is also an assumption that the effects of heroin or barbiturates are so pleasurable and stopping is so unpleasant that addiction can be explained adequately in physiological terms. The addict's relationships with his family and peers are seen to be much less important than his physiological addiction in determining his ability or inability to tolerate abstinence.

Another implicit assumption seen in the literature is

[1]Unless otherwise stated, the addicts described in the literature were heroin addicts.

that drugs, which for the purposes of this paper I will define as any chemicals that affect the mind, have certain effects irrespective of the context of drug use or the characteristics of the user. This hypothesis is what Adler (12) termed the "pharmacological fallacy." There is evidence that it is indeed a fallacy.

Studies of the placebo effect contradict the pharmacological fallacy: they have shown that the context, including the state of the user, is an important determinant of the effects of placebo. Mechanic (13) stated that the two most important variables in placebo response are confidence in those who administer the placebo and a state of emotional arousal in those who receive it. It has been found (8, 14, 15) that a patient's expectation can greatly affect his physiological response, even to the point of reversing the pharmacological action of a drug.

Siegel (16) provided additional evidence against the pharmacological fallacy in his research on heroin use among American soldiers in Viet Nam. He found that withdrawal was universally benign and attentuated among the soldiers in spite of the fact that the heroin used in Viet Nam was often 25 times as potent as that sold on the street in the United States.

In another study (17) it was found that the attitude of the experimenter toward the subject strongly affects the analgesic effect of morphine. This study also found that the majority of normal individuals not experiencing pain find the effects of opiates unpleasant, that many who develop physical dependence in a medical situation tend not to resume taking the drug after withdrawal, and that a rapid development of dependence does not occur on short exposure to heroin.

Lindesmith (18, 19) argued that "addiction" is the result of the effects of withdrawal, but that the effects of the drug depend on a perception that has to be learned. If the individual does not realize that his condition is the result of withdrawal, he does not become addicted.

Addicts are willing to undergo privation and great expense and to enter into criminal careers to acquire their drug. They seem to be unable to tolerate abstinence. Heroin or barbiturates must have a very important function or meaning for addicts because they are willing to go through so much to acquire drugs that have variable context-dependent physiological effects. Since context influences the effects of drugs, it can be assumed that the social context of the addict is an important factor in the inability to stop using drugs. This becomes more obvious if one investigates the social effects of heroin or barbiturates within a most important social context, the addict's family.

THE FAMILY OF THE ADDICT RECONSIDERED

Most of the families of addicts in my sample had the same general characteristics as those described in the literature. However, if one views heroin or barbiturate abuse as a social phenomenon rather than merely the ingestion of chemicals, and if one considers the effects that the beliefs about drugs have on intrafamilial relationships, a different view of the addict's family emerges than the one described in the literature.

The beliefs about drugs that affect family relationships include the following: that it is difficult, painful, and dangerous to withdraw from drug use; that there is a euphoria or "high" gained by drug use; and, perhaps most important, that the addict's behavior is out of control. As a result of the last belief, it is assumed by both the addict and his family that he cannot stop using drugs and that he is not responsible for his behavior when he is under the influence of drugs.

The addict and his family also believe that he is unable to resist drugs if exposed to them. An example of the operation of this belief among addicts is the fact that almost all of the addicts I interviewed stated that they intended to develop friendships with "straight" people because they would not be able to remain abstinent if their friends used drugs.

An example of this belief occurred in a family with two barbiturate addicts. The drug problem was blamed on the neighborhood from which the family had moved because of the prevalence of drug use there. The assumption was that the fact that the boys had lived in that neighborhood inevitably led to their using drugs.

In all of the families in my sample, this feeling of powerlessness against drug use was reinforced by family members. If the addict was abstinent, other family members communicated in various ways the belief that this was a temporary condition.

As a result of the belief in the addict's powerlessness to refuse drugs, the mothers of these addicts felt that their alternatives were limited. They could refuse to let the addict remain at home and force him back to the street and into the company of other addicts, or they could allow him to stay at home and take care of him.

Parental Roles

The mother's role as the protector of the addict was reinforced by the father's demand that the addict stop using drugs and get a job or leave home. The mother blamed her overprotectiveness on her husband's hostility toward their son or her husband's inadequacies as a father. She claimed that her relationship with their son developed only after "trying" to get her husband involved as a parent. The father, in turn, blamed the mother for preventing their son from growing up by overprotecting him.

The fathers were of two general types. One could be termed the "straw-man type." This type was described as authoritarian or violent by other family members but was actually easily controlled by the mother. In one of the families interviewed, the "undeniable" evidence of the father's brutality was a vague incident that had taken place several years ago. In another family, evidence of a stepfather's explosive temper consisted of his wife's reports of harsh treatment of his own children.

The other type of father was also seen as distant from his family, but this type was more clearly secondary to the mother in terms of power within the family. As the brother of a 20-year-old addict stated, "My mother very early won us over . . . . Father sat out in the kitchen."

The father's attempts to control his son's behavior were always undercut by the mother. If the father had a drinking problem, which was frequently the case, he was even less able to take any action against his son's behavior. In several of the families in my sample, the fathers insisted that the addicts work and pay room and board as long as they were living at home. However, their sons remained at home unemployed and using drugs for as long as three years. Thus the addict's behavior was a constant reminder to the father of his weak position in the family.

Conflict between the addict and his father was reinforced by the father's secondary position in the mother's affections and his lack of authority in the household. This was perhaps best expressed by a barbiturate addict who said to his father about his mother, "You can have her back when I'm finished with her." Perhaps as a result of the alliance of mother and son against him, the father was much less involved with the family than the mother. Employment in several jobs often kept him almost totally removed from the family. The mother frequently verbalized her dissatisfaction with his noninvolvement with the family and blamed him for their son's problems, yet this conflict reinforced the father's noninvolvement.

The financial support provided by the father was his one source of gratification; at the same time it was an excuse to remove himself from family conflict. Most of the fathers in my sample had very low expectations of their sons' success. In general, they hoped their sons would find some kind of regular employment, no matter how menial. In fact, it has been stated (20) that fathers of drug addicts actively discourage their sons from striving to achieve success at their jobs.

Only two or three of the addicts in my sample were self-supporting; this support was usually contingent on their drug use. The rest were supported by either their wives, parents, or in-laws. The addict was in a position where the most significant male in his family said, "To be a man you have to work hard and make something of yourself," but his mother said, "You don't have to work because you are sick and can't." In addition, being a "real" man like his father did not appear to be an attractive goal.

The addict was generally seen as inadequate by other family members as well as by himself, his mother, and his father. For example, the twin brother of a 21-year-old addict stated, "Mom looked at you as the weak one. They made you weak." The sister of a 20-year-old addict said that her father told her brother on many occasions that he was not mature enough to go to college and that "nothing was expected of him." There was a consensus within these families that the addict was inadequate and needed help.

Parental Conflicts

The marital dyad in these families was characterized by emotional distance and a lack of interaction—except for those periods when the addict seemed to need the most help, i.e., when he was using drugs or his parents thought he was using drugs. The mutually accepted belief that the addict is unable to resist drugs functioned to make his parents interact, if only to argue about him. This kind of interaction created even more tension in the household, and the addict generally responded by increased drug use. One barbiturate addict in my sample stated that the only time he was able to enter into a dinnertime conversation with both his parents at the same time was after he had used drugs.

Problems in the parents' relationship were acted out through disagreements about the addict's drug use and his lack of employment. The mother generally verbalized her displeasure at her son's behavior but seldom really attempted to change it. Several addicts reported that their mothers found their heroin or their hypodermic needles and did not destroy them. Gibson (21) reported that the mothers of some addicts force their sons to leave home when they are not using drugs but encourage them to live at home when they are using them. One of my patients, a heroin addict, told me that some mothers leave money around for their sons to steal in order to buy drugs.

As a result of the familial conflict focused on his behavior, the addict saw himself as powerless and at the same time to blame for the problems between his parents. He was drawn into the conflict by supporting his mother or being attacked by his father and being supported by his mother, which reinforced the conflict between the parents.[2] This eventually caused the addict to withdraw from any interaction at home or to seek relief away from home. Either behavior made the mother even more anxious because withdrawal from the family indicated he was unhappy and more likely to use drugs. Her anxiety communicated to the addict that she felt he could not resist drugs.

In the attempt to "convince" the addict not to use drugs the parents inevitably disagreed as to what steps should be taken to stop his drug use; this caused even more tension within the parental dyad. The addict's drug use therefore continued, and everyone in the family felt helpless to solve the problem, particularly the addict. He learned that he could not really stop and that his family could not help him stop. He was not presented with any real alternatives because he was seen as being unable to resist drugs.

The belief that the addict is unable to control his drug use and therefore needs help reinforced the close relationship between the addict and his mother. However, another belief about heroin, that it reduces sexual interest,[3] was perhaps necessary to reduce the incestuous fears of the addict. The need for heterosexual activity with other women, which might have been anxiety producing because of the addict's low self-esteem, was eliminated by this belief. In my sample, all of the addicts stated that they had little sexual interest when addicted. At least half of them verbalized fears about heterosexual relationships and whether they could perform adequately sexually.

[2]The special relationship between the addict and his mother frequently created hostility between the addict and his siblings, who resented the special treatment given him.

[3]This does not appear to be part of the mythology of the barbiturates.

CONCLUSIONS

The addicts in this sample had inadequately separated from their families because of certain aspects of their parents' relationship. Their mothers' most intimate relationship was with the addict, whom they overprotected and infantilized in an effort to maintain the relationship. The addict's view of himself as unable to abstain from drugs reinforced what he and his mother felt to be the necessity to take care of him. As a result, the addict was unprepared for adult responsibility, and his addiction was a "legitimate" means of absolving himself from it. The mother was then able to "legitimately" take care of him. Thus as long as he remained addicted he would be taken care of by his mother. This alleviated his guilt about the anxiety he created in his mother when he attempted to separate.

The addict's relationship with his mother also exacerbated the distance between the addict and his father, whom the addict had replaced in the mother's affections. The mother defended the addict against his father, which created constant conflict between the parents revolving around the addict. Each parent blamed the other for the addict's condition; the addiction was a constant reminder that they were failures as parents.

At the same time the addict was able to maintain at least some relationship between his parents by his continued drug use. The father was drawn back into the family enough to fight with his wife about the addict and to blame her for the problem. Attempts on the part of the addict to leave caused anxiety in the addict and his mother, as did his remaining in the household; there was perpetual conflict whether the addict stayed at home or not.

The addict was caught in a paradox. He had been taught that to be a man one must work, but at the same time he was covertly encouraged to remain at home unemployed as long as he used drugs. Within the family much of the interaction focused on trying to "convince" the addict not to use drugs, which implied that he had some control over his drug-related behavior. At the same time, all family members viewed the addict as incapable of resisting drugs. The result was that the addict continued to use drugs. This was reinforced by his social interaction outside the family, which was primarily among drug users or people involved with drugs. The relationships outside the family were generally nonintimate and transient.

The addict's concern with drugs eliminated almost all extraneous stimuli. As Stephens and Levine (22) stated, the subculture provides the addict with a set of norms and a way of life. This was reinforced in the families in my sample, in which the addict's parents told him that he could not resist using drugs if he was with drug users. As a result, if the addict was with friends who were addicts, he would most likely continue to use drugs.

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A Teaching Drill in Child Psychiatry

BY RITA R. ROGERS, M.D., AND BEATRICE RASOF, PH.D.

The authors report on a teaching drill for psychiatric trainees that tests their ability to communicate child psychiatry concepts to a nonpsychiatric physician and to parents of a disturbed child as well as their abilities in the role of a supervisor and a "visiting professor." It was found that the drill was a learning experience for the trainees that focused attention on their problems in integrating their psychiatric skills and identity with their identification with the medical model.

ONE OF THE MOST DIFFICULT tasks in educating psychiatric residents is that of integrating their acquired psychotherapeutic skills and psychodynamic understanding with their identity, knowledge, and skills as physicians. As the young psychiatrist becomes more skilled in conducting nondirective interviews and as his own behavior and responses to patients become reliable tools in his specialty, he may experience disdain for the recently acquired tools of a physician and feel inclined to dismiss them.

The medical style of history taking and recording appears to be an unnecessary responsibility; the idea of diagnostic categories seems rigid and meaningless, a way of forcing personalities into boxes. The psychiatrist in training who uses himself as a medical diagnostic tool feels restrained by medical "rigidities"; in his haste to develop the psychiatric "artistic" identity he becomes sloppy and negligent in his medical scientific inquiry. He seems to avoid committing himself to diagnosis, prognosis, and recommendation.

In response to this a teaching drill was designed for and practiced with psychiatric residents to help them bridge their identities as child psychiatrists and as physicians operating within the medical model.

THE TEACHING DRILL

Five groups of two students each were established for supervision: two second-year fellows in child psychiatry, two first-year fellows in child psychiatry, two third-year general psychiatry residents taking their elective in child psychiatry, two third-year residents in the required program, and two second-year general psychiatry residents rotating in child psychiatry.

The supervision drill took an hour and a half with each group. Its format consisted of one resident's giving a 10- to 15-minute report to the supervisor on a child whom he had evaluated during the preceding week and on the child's parents. He was required to give his report as if his supervisor were a nonpsychiatric medical referral source (the referring physician), emphasizing concise, pertinent findings about the parent-child relationship. The primary purpose here was to establish a therapeutic alliance with the referring physician, to thank him for his referral, and to inform him about findings and objectives. Special emphasis was placed on translating the psychiatric point of view into acceptable medical norms, standards, and styles for the nonpsychiatric physician. For example, a 13-year-old's request to be placed in a juvenile hall was translated as his attempt to signal his fear of losing self-control.

In the second part of the drill the resident conducted an interpretation interview with the child's parents. This interview took 30 minutes and was conducted in the presence of the supervisor and the other resident in the group (the resident observer). The first resident conveyed his impression of the child to the parents by asking for their view of the child and his behavior. Emphasis was placed on questions like "Why do you think he steals only from you?" and "How did you feel about his tic subsiding while he was in the hospital?"

Although the interview was conducted in the open-ended style of a diagnostic or therapeutic session, the parents were told what the child suffered from, how parent-child communication functioned, and what the recommendation for treatment was. The resident also told the parents who the primary patient was, which parent needed treatment and why, and what psychotherapy was.

In the third part of the drill the resident observer gave a 10-minute discussion of his colleague's interviewing technique. He asked questions about the style of interviewing and assessed his colleague's use of himself in interviews. (This part of the drill seemed valuable in training residents to be future supervisors and teachers. Further, it seemed to increase acceptance of supervision and foster cooperation and identification with the staff supervisor.)

Finally, the resident who had interviewed the parents of the child discussed the dynamics of the case in psychiatric terms with his supervisor and the resident observer. He was instructed to discuss his case as if he were a visiting professor attending a psychiatric conference where a patient had been presented to him. Here the drill emphasized articulation, clarity, knowledge of the literature, and professionalism as a psychiatrist.

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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GENERAL FINDINGS

All of the residents were reluctant at first to commit themselves to an exercise in psychiatric training; they thought it was infantilizing at this advanced stage of their education.

They thought it premature and superficial to commit themselves to diagnosis, prognosis, and a definite course of treatment after knowing patients only a short time (one week). They were especially reluctant to offer a diagnosis and prognosis to a nonpsychiatric referral source. In short, they felt confined in their psychiatric breadth by the "stilted" medical model.

Their talents as psychiatrists varied—especially their abilities to do several things simultaneously. They had to report to a referral source and at the same time subtly convey mental health principles to a nonpsychiatric physician. They had to conduct an open-ended interview with parents and at the same time interpret for them their view of the child and the sources of this view. They had to express psychodynamic formulations with clear-cut delineations of what they knew, thought, and felt about the case.

The residents' therapeutic skills were particularly taxed in their efforts to establish a therapeutic alliance with a referring physician while subtly linking him to the psychiatric point of view. They also had to establish a therapeutic alliance with parents while making them aware of the emotional sources of their views of their children.

In general, cooperation was strongly influenced by the resident's feelings toward the supervisor (R.R.R.), who was chief of the child psychiatry division.

METHOD OF ANALYSIS

In order to measure quantitatively the usefulness of the teaching drill, six questionnaires were designed.[1] Questionnaire 1, filled out by the supervisor, measures the trainee's performance as a physician reporting his findings to a nonpsychiatric referral source (the role-play situation). Questionnaire 2, filled out by the supervisor, measures the trainee's ability to translate psychiatric findings to parents. Questionnaire 3, filled out by the child's parents, measures their impressions of whether or not they received a clear and empathically translated diagnosis. Questionnaire 4, filled out by the supervisor, measures the resident observer's ability as a supervisor. Questionnaire 5, filled out by the resident observer and the supervisor, evaluates the trainee as a "visiting professor." Questionnaire 6, filled out by the trainee, evaluates the teaching drill itself.

These questionnaires were used from November 19, 1973, to March 4, 1974. They measured findings on 29 patients (a total of 261 questionnaires). The sample of 10 trainees and 29 teaching drills that is reported here (see appendix 1) is an attempt to tabulate our findings and to measure the efficiency of the drill by means of data analysis. This is only a pilot study; the drill is continuing.

[1] These questionnaires are available from the authors on request.

RESULTS

The data selected for discussion were examined in a number of ways within the limits imposed by the sample and time. We confine ourselves here to a descriptive treatment of the findings representing the areas measured by the six questionnaires. Tables 1 through 6 give the proportions of positive responses or proportions of ratings in the upper half of the distribution in each of the six areas. Particular variables of interest were selected for more refined analysis.

Role Play with Referral Source

As shown in table 1, all of the psychiatrists in training tested were able to tactfully convey information to a referral source, discuss the patient's symptoms and their meaning, and give treatment recommendations with a degree of clarity in the upper half of the rating-scale distribution.

The weakest areas of performance were in giving a diagnosis, making a therapeutic alliance, and conveying mental health concepts. Not one individual discussed prognosis. Nevertheless, considering the transaction as a whole, the group was rated in the upper half of the rating scale in 21 of 24 instances; the median rating was 2.5 (a rating of 1 was highest, 6 lowest). The advanced child fellows did significantly better than the combined group of second- and third-year residents in giving a diagnosis ($p = .0064$, Fisher's exact probability test).

Interpretation Interview with the Parents

As seen in table 2, treatment recommendations were made to the parent of the patient in fully 90.9 percent of the cases; the degree of empathetic understanding shown was rated as above the median rating for 78.3 percent of the residents. The rationale for treatment was not given as often; in more than one-third of the cases the combined group of residents and fellows were not able to effectively translate the child's problems into language the parent could understand. A diagnosis was given in only 45.5 percent of the interviews and with only a moderate degree of clarity (median = 3). In very few cases was the meaning of psychotherapy explained. In no instance was prognosis discussed.

Almost three-fourths of the interviews conducted were rated in the upper half of the distribution (median = 2). A comparison of the effectiveness of the transaction as a whole conducted by child fellows compared with the second- and third-year residents indicated a difference in favor of the fellows at a lower level of confidence than in the role-play situation ($p = .13$, Fisher's exact probability test). A more representative sample might be expected to confirm the greater proficiency of the more highly trained psychiatrists who have chosen child psychiatry as a specialty.

TABLE 1
Frequency Distribution of Role-Play Interview Evaluations, in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Psychiatric information about the child translated into acceptable medical norms	55.0	
Symptoms and their meaning discussed	84.0	
Diagnosis given	52.2	
Treatment recommendations made	77.3	
Prognosis given	00.0	
Therapeutic alliance with referral source made	54.2	
Mental health concepts conveyed	66.7	
Clarity with which symptoms and meaning discussed		95.4
Clarity with which diagnosis given		100.0
Clarity with which recommendations made		82.4
Tact with which mental health concepts conveyed		100.0
Evaluation of transaction as a whole (understandable language as opposed to jargon)		87.5

TABLE 2
Frequency Distribution of Interpretation Interview Evaluations, in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Translation of information about the child's problem into language the parent can understand	65.2	
Discussion of symptoms and their meaning	47.2	
Diagnosis given	45.5	
Treatment recommendations made	90.9	
Rationale for treatment given	61.9	
Modality of treatment given	73.9	
Primary patient identified	65.2	
Parent in need of treatment identified and reason stated	81.9	
Explanation given of what psychotherapy is	23.8	
Prognosis given in terms parent can understand	0.0	
Clarity with which symptoms discussed		100.0
Clarity with which diagnosis given		100.0
Clarity of treatment recommendations		92.3
Completeness of recommendations (overall rating)		60.9
Empathic understanding and communication shown		78.3
Overall effectiveness of interview		73.9

TABLE 3
Frequency Distribution of Evaluation of Resident Observer as Supervisor, in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Appreciation of difficulties encountered by interviewer	81.3	
Understanding of interactional process between interviewer and patient	81.1	
Resident has ability to provide alternative ways of handling difficulties encountered	56.2	
Resident contributes over and above what staff supervisor contributes	50.0	
During role play	56.2	
During interpretation interview	62.5	
During "visiting professor" role	56.2	
Sensitivity to the interviewer shown		87.5
Clarity in communicating understanding of the interactional process		100.0
Overall evaluation of resident observer as supervisor		62.5

Of particular interest is the finding of no significant difference between the median rating of the favorableness of the interpretation interview given by the trainee when compared with that given by the supervisor.

Resident Supervisor Interview

As shown in table 3, the resident observers in the role of supervisor were to a high degree sensitive and appreciative of the difficulties encountered by their fellow trainee in the interpretation interview. The resident supervisors were usually able to understand the interactional process between parent and interviewer and to convey this clearly. To a lesser extent they were able to provide alternate ways of dealing with problems that arose during the interview. In from 50 to 60 percent of the interviews or role-play situations the resident supervisor was able to contribute ideas over and above those provided by the staff supervisor.

A highly significant difference between the residents and child fellows was noted in comparisons of their overall evaluations as a supervisor. The null hypothesis that the proportion of trainees with ratings 1–3 and ratings 4–6 in the supervisory role was equal for residents and child fellows was rejected ($p=.0003$, Fisher's exact probability test).

Evaluation as "Visiting Professor"

As shown in table 4, there appeared to be less variability in this section of the drill. All trainee psychiatrists

TABLE 4
Frequency Distribution of Evaluations of Trainee as "Visiting Professor," in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Psychiatric information about the case translated into suitable conceptual framework	85.0	
Knowledge of the literature incorporated in meaningful way	5.0	
Clarity with which psychiatric information communicated		100.0
Articulation with which psychiatric information communicated		100.0
Professionalism shown		100.0

who were able to translate psychiatric information about a case into suitable conceptual terms did so with a very high level of clarity and articulation (median rating = 1.0). In striking contrast, only 5 percent incorporated knowledge of the literature in a meaningful way into the case discussion.

Parent Interview Survey

As shown in table 5, the parents reacted favorably to the interview; 84.2 percent made judgments in the upper half of the rating scale (median = 1.5). The degree of understanding parents attained about their children after the interview was closer to the center (median = 3.0) but 90.5 percent felt they understood their children somewhat better or much better than before. Almost all of the parents also reported getting all the information they needed. The more prominent emotions checked on the list were feeling understood by the interviewer and feeling optimistic. Less than half of the parents (36.4 percent) reported feeling more anxious and 27.3 percent reported feeling less anxious than they had felt before the interview.

It is interesting to compare the parents' perception of the interpretation interview with that of the supervisor. In the sample of 19 cases, 8 individuals rated the interview as better and 7 as worse than did the supervisor; 4 rated the interview the same. Thus the median of the ratings made by the parents did not differ significantly from the median of the ratings made by the supervisor at usual levels of significance using the sign test. Equally interesting was the finding of no significant difference between the median self-rating of the trainee and the median rating of the supervisor.

Evaluation of the Teaching Drill

As shown in table 6, the evaluation of the drill by the participating residents and fellows indicated that in 78.1

TABLE 5
Frequency Distribution of Parents' Evaluations, in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Overall reaction to interview		84.2
Understanding of child's problem after interview		90.5
Desired information discussed	90.9	
Recommendations and steps to be followed presented clearly	90.9	
Feelings during or after interview		
Pessimistic	18.2	
Angry		
At therapist	13.6	
At child	0.0	
At self	4.5	
At others	4.5	
Optimistic	45.5	
Ashamed	9.0	
Disappointed	9.0	
More anxious than before coming to clinic	36.4	
Less anxious than before coming to clinic	27.3	
Misunderstood by interviewer	13.6	
Understood by interviewer	81.9	

TABLE 6
Frequency Distribution of Evaluations of Teaching Drill, in Percents

Variable	Proportion of Positive Responses	Proportion of Ratings in Upper Half of Distribution
Descriptions of drill		
Impractical	2.8	
Artificial	0.0	
Stimulating	62.9	
Well conducted	74.4	
Forced one to think more clearly about patient's dynamics	68.6	
Clarified perceptions and misperceptions about ongoing interactions	65.7	
Feeling during or after drill		
Angry	8.6	
"Put down"	0.0	
Stupid	5.7	
Satisfied	62.9	
Had done a good job	17.1	
Other*	—	
Retain teaching drill as it is	78.1	
Comparison of drill to one-to-one supervision		77.2
Attitude to role-play supervision		88.2
Sensitivity of supervisor to training needs		91.5
Feeling of openness in discussing interview with supervisor		91.5
Better understanding of how to integrate theory and case studies from literature		78.1

*The open-ended replies were not tabulated.

percent of the sessions rated they would retain the entire teaching drill as it is. An almost equal proportion felt that what was learned by this method could not be as readily learned in the usual one-to-one supervision. The role-playing situations were found valuable in 88.2 percent of the interviews. Particularly high was the rating of feeling of openness in discussing the interview with the supervisor. Sensitivity to the learning needs of the trainee was rated equally high. A large number of the drills were found to be stimulating, well conducted, and successful in forcing the trainee to think clearly about the patient's dynamics and in clarifying perceptions and misperceptions about ongoing interactions. None of the trainees found the drill to be artificial, and in only one instance was the drill considered impractical. In the majority of the sessions, the trainees felt that they had attained a better understanding in integrating theory and case studies from the literature into their style of reporting to a referral source or seminar.

The Clinician-Supervisor as "Computer"

There was some satisfaction in the finding that the overall clinical judgment of the rank order of the trainees' performance made at the end of the study by the supervisor was significantly related to the rank order based on an average of the ratings made at the time of the drill sessions (rank correlation of .78, $p = .01$, $N = 10$).

USES OF THE DRILL

While the drill seemed a valuable exercise for future practitioners, teachers, and supervisors, its primary aim was to link the residents' psychiatric and medical identities, which appeared far apart.

The results show that the psychiatric trainee is indeed accomplished in understanding and conveying clinical data but that he has a definite disinclination toward committing himself to a diagnostic framework and completely avoids voicing a prognosis, in spite of the repeated filling out of questionnaires that included the category of prognosis. Both the avoidance of diagnostic formulation and resistance to uttering a prognosis seem related to the psychiatrist's estrangement from the medical model. The psychiatric trainee almost always recommended treatment although he had not given a prognosis in the role-play situation and had given a diagnosis to the parents in only 45.5 percent of the interviews.

The trainee seems to identify himself primarily as a psychotherapist, but he finds it difficult to clarify what psychotherapy is. He does not feel a responsibility to define to the parents what ails the child and how he will treat the difficulty.

In the role of supervisor the trainees showed a high degree of sensitivity toward their colleagues' difficulties but a limited ability to provide alternative ways of handling them. (This is probably due to uncertainty and inexperience in the role of supervisor; all the trainees have been recipients of supervision, but few have had the opportunity to supervise.)

The drill did not increase the trainees' responsibility toward the medical model of diagnosis and prognosis. It only brought their avoidance into focus and highlighted the need to search for the causes of this avoidance both in the training program and in the trainees' identity as psychiatrists.

The drill did help the trainees in other areas, however. They became more skilled and articulate as they gained confidence in their abilities to translate findings from one mode to another—from the medical language used in their reports to the nonpsychiatric physician to the therapeutic language appropriate to the emotional milieu of the parents to the didactic language appropriate to psychiatric conferences.

The trainees' ability to fulfill the different roles required of them depended on their security as people and as psychiatrists, on their relationship with their supervisor, and to some extent on the nonambivalence of the psychiatrists who had been important models during their entire psychiatric training.

The supervisor (R.R.R.) found that the drill provided an invaluable glimpse of the psychiatrist in training. She found her greatest reward in the opportunity to see some of her trainees' skill and ease in functioning as accomplished psychiatrists as they faced the tasks of understanding and being understood by their patients.

APPENDIX 1

Explanation of the Sample

The data reported in this paper cover the period of time from November 19, 1973, through March 4, 1974. The sample size reported in the tables is sharply reduced by the decision to use only those ratings made by one supervising staff person (R.R.R.). Twenty-three drills in which the patient was present and in which the interview was carried out by the trainee were conducted by Dr. Rogers.

In one session Dr. Rogers conducted the interpretation interview at the request of the trainee. Child fellows supervised the others while Dr. Rogers was absent. The trainee participated both as an observer and as a resident supervisor, along with the major therapist. The number of different patients interviewed by each trainee is the variable factor. Two trainees participated in 5 and 6 drill sessions respectively, 4 conducted 3 each, 2 conducted 2 sessions, and 2 conducted 1 each for a total of 29 teaching drills carried out by 10 trainees.

DISCUSSION

ROBERT E. SWITZER, M.D. (Topeka, Kans.)—I am grateful to Dr. Rogers and Dr. Rasof for this description of their innovative system for judging how child psychiatry fellows and general residents in psychiatry are able to bridge their identities as physicians and as specialists in child psychiatry. This drill asks the trainees to do a very difficult thing: to look at their own performance. They are asked to open themselves up to the scrutiny of a peer as well as the scrutiny of a teacher and to do it in terms of role playing.

If the trainee does not already have plenty of doubts about

his findings, his formulations, his diagnosis, and his recommendations, not to mention prognosis, the thought of reporting back to a nonpsychiatric referral source after having seen his patient for only one week is bound to put him on the defensive and to cause some struggle in terms of his identity as a physician and as a psychiatrist. I can identify with the trainee's struggle in not wanting to commit himself. I well remember my days as a first-year resident; we all wanted to wait for the psychological report before we really committed ourselves. I think the first part of this drill is excellent and I see it as applying rigor rather than infantilization.

The second part of the drill, which calls for interpreting the child's problems to his parents, gets a little more complicated. Many residents would certainly see this sort of experience as infantilizing and very threatening. Only great skill on the part of the supervisor and repeated experiences could make this part of the drill a very positive and growth-promoting experience. It seems to me that I have known some supervisors who might never rise to this occasion.

I think the third part of the drill, in which the resident observer takes the role of supervisor, is excellent. I have used twin supervision of residents in diagnostics as well as in psychotherapy for a long time. It seems to me that it may be useful when assigning the two residents to take this drill to let the residents participate in choosing their drill mates. I agree with Drs. Rogers and Rasof that this part of the drill is a good way to teach a young clinician some supervisory techniques.

In the fourth part of the drill the resident can allow himself to assume the senior visiting clinician's role after having explained to a referral source and to parents his findings and thoughts about the case. This part of the drill may be a little stilted. I shared this paper with a third-year resident who thought that the paper was fine and that he would like to participate in such drills. However, he had a criticism of the fourth part of the drill. He thought that it assumed a visiting professor had to be pompous and verbose and had to say things in a different way than he would to a referring physician or a troubled parent. He thought that the really secure physician-psychiatrist would not be too different in any of the three roles outlined in the drill.

The authors found a tremendous variety in the performance of the residents according to their level of sophistication in child psychiatry. I would think that there would also be tremendous differences between the residents who came into psychiatry right out of medical school without an internship compared with those who had had long periods of private general practice or military or Public Health Service duty. I would also predict, as Drs. Rogers and Rasof found, that a great deal of the resident's performance would be related to his relationships with his supervisor and with his peers.

It would seem logical to assume that second-year residents in general psychiatry would have much more difficulty with this drill because of their short experience in dealing with children and their parents when compared with second-year fellows in child psychiatry. In addition to having had considerably more experience the fellows also probably had the advantage of having worked with this supervisor for at least a year before the drill. In that sense the drill and its documentation could well be taken as a test of training, i.e., a second-year fellow who does much better in this drill than he did as a first-year fellow might be said to have profited by his second year and to have become more efficient in the skills taught. In another sense the drill could be used to select residents who might be urged to go into child psychiatry.

This paper represents the first complete sampling of the drill and its questionnaires. It may be that the data have not yet been analyzed well enough to answer all of our questions. I had one thought about prognosis. It would seem to me that the finding about the trainees' failure to give parents a prognosis would persist. It has been my observation that trainees have great difficulty with their inability to talk definitely about prognosis. I would really wonder about a fellow who spontaneously got into a discussion of prognosis.

Sexual Dysfunction in College Men and Women

BY ARNOLD WERNER, M.D.

The author presents data and illustrative excerpts from 1,000 letters relating to health and personal concerns that were sent to his column in a college newspaper. There were 532 letters expressing sexual concerns, 65 percent of which raised questions about anatomy and physiology. A comparison of the distribution of problems of sexual dysfunction in this study with that of an earlier study involving older patients showed very different distributions. The author points out the need for sex counseling and education for young people who are sexually active and discusses the unique problems involved in treating this population.

THE LARGE INCREASE in the amount of sexually oriented material presented to the public suggests that there is now a greater openness about sexual matters in this country than has existed in the past. Explicit motion pictures, illustrated magazines, and books abound. In addition, instructional manuals and digests of sex research with the ostensible goal of improving the reader's sexual capabilities are sold widely. Many colleges offer courses in human sexuality, and sex counseling services are becoming available on college campuses (1).

With increased sexual awareness, people may be less willing to accept sexual dysfunction than they were in the past, and adequate sexual performance may become part of their definition of a complete life. It is certainly true that interest in sexual functioning is no longer considered too private to discuss or too deviant to acknowledge.

Revised version of a paper presented at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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A NEW SOURCE OF INFORMATION ABOUT HEALTH AND PERSONAL CONCERNS

The clinician's knowledge of people's frailties usually comes from his patients. The hazards of generalizing our observations of such a highly selected group are well known, yet there are few opportunities for gathering information from any other source. Information about the sexual activities and concerns of college students is particularly difficult to obtain.

Because of an ongoing project of more than four years' duration, I have been in a unique position to gather information about the health and personal concerns of college students. With the development of psychiatric services at the Michigan State University Health Center, I began to write a weekly column dealing with these concerns for a student newpaper. The paper, which is published daily, has a circulation of 40,000 and is the prime source of news for most of the student body. In addition, it has a wide readership in the community. The goal of my column, which is called "The Doctor's Bag," is to provide a service to the university and to promote attitudes and offer dispositions consonant with the aims of college and community mental health.

The papers in this section are grouped around a specific topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.

By offering myself as a free, confidential source of information, I became the recipient of many hundreds of letters from students seeking advice and answers to personal questions. In addition to publishing students' letters and answers to their queries, I tried to answer all the letters that were not published as long as the writer was identified.

The column provides rich personal accounts of health and other concerns. Unlike other data, which are often anecdotal, i.e., obtained from patients and/or structured, preestablished survey instruments, the material I obtained dealt with the private concerns of students. The categories, formulations, and centrality of these concerns were structured by the students themselves. Although the column appears in about 50 college newspapers, the material for this study was all derived from Michigan State University students.

ANALYSIS OF STUDENTS' CONCERNS

Content analysis of 1,000 consecutively received letters revealed that 52 percent contained sexual questions, which confirms the generally held impression that college students have many questions about sex. As table 1 shows, the questions often revealed a striking naïveté and lack of information: 65 percent of the sexual questions related to basic physiology and anatomy, the mechanics of contraception, and venereal disease. The other 35 percent were concerned with sexual activity. Over 30 percent of the questions relating to sexual activity dealt with sexual dysfunction. (These letters represented 5.6 percent of the total sample of 1,000 letters.)

These 56 letters were categorized on the basis of whether the problem was primarily a woman's or a man's concern. Within each category, I followed the definitions of dysfunction used by Masters and Johnson (2) whenever possible. All judgments about dysfunction were based on statements in the letters rather than my own inferences. This categorization is presented in table 2.

TABLE 1
Breakdown of Concerns Expressed in 1,000 Letters from College Students

Type of Question	Number	Percent*
Sexual questions (N=523)		
Anatomy and physiology	340	65
Venereal disease	22	7
Contraception	99	29
Female anatomy	151	44
Male anatomy	68	20
Sexual activity	183	35
Sexual intercourse**	104	56
Oral and anal	32	17
Petting	26	14
Masturbation	18	10
Homosexuality	3	2
Nonsexual questions (N=477)		
General health	202	42
Medical	186	39
Psychological	46	10
Drugs	43	9

*Percentages within each classification are based on the total number for that category alone.
**Includes all questions related to sexual dysfunction.

TABLE 2
*Breakdown of the 56 Questions Related to Sexual Dysfunction**

Type of Question	Number	Percent**
Questions related to men's problems (N=27)		
Premature ejaculation	16	59
Impotence	6	22
Primary	3	50
Secondary	3	50
Ejaculatory incompetence	1	4
Other	4	15
Questions related to women's problems (N=32)		
Orgasmic dysfunction	24	75
Primary	8	33
Situational	16	67
Other concerns	8	25
Painful intercourse	4	50
Low sexual interest	2	25
Other	2	25

*Three letters were classified as related to both men's and women's problems since the writer wrote of a mutual concern.
** Percentages within each classification are based on the total for that category alone.

CONCERNS RELATED TO SEXUAL DYSFUNCTION

Women's Problems

The problems of women cause distress to their partners, and 6 of the 32 letters relating to female sexual dysfunction were written by men. However, in each case, the man saw the problem as being solely the woman's concern rather than a joint problem. There were four letters about painful intercourse. The three involving pain with penetration were written by men. There were three letters describing situations in which the woman suffered from orgasmic impairment and the man had premature ejaculation, all of which were written by women.

The bulk of concerns related to female sexual dysfunction clearly involved orgasmic impairment. These problems covered a considerable range. One woman wrote, "My fiancé is able to reach a climax even though I cannot. While I love him I do not enjoy intercourse, but I feel I should engage in it for his sake." The female partner of a married couple wrote, "I am no longer interested in sex. I have no drive and it takes quite a bit of stimulation to get me the least bit interested." She then described the onset of the difficulty following several urinary tract and vaginal infections and stated that she was concerned that

her marriage would eventually be jeopardized. Complaints concerning coital orgasmic dysfunction usually indicated that orgasm was possible with manual stimulation either before or after intercourse.

Since the population studied consists of young adults, some of the problems in the letters had a particularly youthful quality, often tinged with lack of experience or knowledge. The following excerpt is an illustration:

> I am 20 years old. My boyfriend and I have been having intercourse for a year now, but only on weekends since he goes to another school. I have never had an orgasm from intercourse alone. I have had orgasms as a result of clitoral stimulation during masturbation. My boyfriend never touches my clitoris. Is there something wrong with me? Am I undersexed?

Another coed wrote that she had learned in a human sexuality course that women are capable of multiple orgasms but that she herself was not.

> During intercourse my boyfriend is able to achieve more than one orgasm whereas I am only able to achieve one. I am very satisfied and fulfilled after having intercourse but can't help but feel that I should be able to have more than just one orgasm. What is wrong with me?

There are glimpses in the letters of the beginning of sexual problems that will undoubtedly persist. Often, these women were aware of the threat to their future happiness.

> We have been making love for two years and will be getting married in about one year. This is great. The problem is that I am not very interested in sex . . . I have never come close to an orgasm. Lately, it sort of panics me—here is a man I'll be living with for decades, and I can't even respond to him.

An older student presented a situation of a similar nature that was further along the continuum of distress.

> During our marriage I have never climaxed with intercourse, only manually on occasion. I have little enthusiasm for sex, and this coupled with my husband's frustration at not being able to satisfy me has sadly corroded our marriage. For many reasons, including children, we do not want a divorce; neither do we look forward to continuing the situation.

While there were no complaints about inability to reach orgasm by masturbation, several women were concerned because they could only achieve orgasm during sexual intercourse in certain positions, usually the female superior position. Included in the group of women who had situational orgasmic dysfunction are those who at one time had no difficulty but currently were troubled. A few of these women gave histories in which the use of oral contraceptives was coincident with diminished sexual response. Others wrote of success with a previous partner but failure with a current partner.

Twelve correspondents in this group asked for referral to a treatment source. Some had previously had difficulties in their attempts to seek help. In some cases, the difficulty was related to the writer's single status and to the insensitivity they perceived in traditional care givers. One writer simply asked, "Do you know of anyone who counsels people who are not married?"

All of the letters related to female sexual dysfunction communicated considerable distress and disruption. There were no idle inquiries prompted by curiosity, as is often the case in letters I receive that deal with other health concerns.

Dysfunction In Men

Table 2 also presents a breakdown of the 27 inquiries about male sexual dysfunction. It should be noted that three problems have been classified in both this group and the female group because the writer so clearly identified the dysfunction as a mutual problem. These three letters were those written by women with orgasmic dysfunction who had partners with premature ejaculation. Another fact worthy of note is that all of the letters in the male dysfunction category written by women concerned premature ejaculation rather than impotence.

Premature ejaculation was the largest single source of concern in all of these letters. Some of the situations described were quite explainable and relatively benign. One such letter included the following:

> During sexual encounters I seem to reach orgasm very fast, always having at least one before intercourse begins . . . They even occur at odd times as when I was giving my girl a back massage. Could it be related to the fact that I never see my girl more than once a month and always feel a high degree of excitement when I do?

In some ways, this quote typifies the problems of younger people who are sexually active. These couples maintained high expectations, even though they had intercourse on an irregular basis under circumstances that were often rushed or awkward. The goal of helping people achieve good sexual functioning under such circumstances is complicated.

Many of the letters dealing with premature ejaculation indicated that this was an isolated concern in an otherwise satisfactory relationship, but there were times when the problem dominated interpersonal interactions. For example, a 21-year-old man wrote letters to me on two occasions separated by about 10 weeks. Describing himself as a shy person in his initial letter, he asked for advice in managing a situation that had developed in his first close relationship with a woman. He was alternately unable to get an adequate enough erection to achieve penetration or he ejaculated before entry. He perceived his girlfriend, who was understanding at first, as becoming less tolerant, and felt that the relationship was threatened. His second letter indicated that the relationship had ended. This was the only letter in which dysfunction was blamed for actual termination of a relationship, and the author clearly expressed self-doubts that extended beyond sexual performance.

The problem of primary impotence as an isolated entity appeared only twice in the letters. In one of these

cases, erection was repeatedly lost so quickly after entry that successful intercourse was never accomplished. The other case barely qualifies as a problem of primary impotence as it was a failure during a first attempt at intercourse with a virginal girlfriend. Advice and reassurance were requested by writers of these letters, who were distressed and puzzled. They often asked for an explanation of what was happening. Those who were impotent were more generous in postulating hypotheses for their disorder. They indicated that feelings of inferiority, inadequacy, lack of confidence, and unspecified psychological explanations might be pertinent. In a similar vein, three of the male correspondents expressed the fear of eventually becoming impotent, even though their letters provided no objective evidence that such fears were justified.

One case of ejaculatory incompetence emerged in a 19-year-old.

> I cannot ejaculate willfully. The only time I ejaculate is during sleep in the form of a wet dream. This bothers me greatly as I am unable to masturbate and cannot come, even when my girlfriend has oral sex with me.

DISCUSSION

The writers of letters to my column have typically been uninhibited in the questions and concerns they have raised. By answering virtually any type of health question in this public format, I have encouraged viewing all concerns as legitimate. While there is no way to ascertain accurately how representative these correspondents are of the entire student population, much valuable information can be derived from this nonpatient group.

Sexual dysfunction is a small concern in this group compared to all other health concerns (56 of 1,000 letters). The intensity of distress expressed in these 56 letters was quite great, exceeded only by the frightened individuals who were worried about an unwanted pregnancy. Among those individuals who raised questions about sexual activity, however, almost one-third dealt with dysfunction.

Table 3 presents a comparison of the 56 correspondents in my sample with concerns related to sexual dysfunction to 790 patients described by Masters and Johnson (2). The two populations are vastly different. Masters and Johnson's group consisted of highly selected patients who often had severe problems. They were also older, ranging from 23 years old to 76 years old. (Their youngest patient was probably older than the median age of my correspondents.) Because the groups are so different, the comparison is all the more interesting.

A much smaller percentage of woman in my study suffered from primary orgasmic dysfunction. Apparently, despite their inexperience, the young women in this study were having less difficulty having an orgasm at least one time than they were having orgasms regularly. The possibility is raised that younger middle-class women are having less difficulty in achieving initial sexual satisfaction than older women had. Considering the academic, financial, and social stresses young women are under, the finding that situational orgasmic dysfunction is a major concern should be no surprise.

TABLE 3
Comparison of Types of Sexual Dysfunction Reported in Two Studies, In Percents

Nature of Dysfunction	Masters and Johnson Study	Present Study
Female dysfunction	(N=342)	(N=24)
Primary orgasmic dysfunction	56	33
Situational orgasmic dysfunction	44	67
Male dysfunction	(N=448)	(N=23)
Primary impotence	7	13
Secondary impotence	48	13
Premature ejaculation	41	70
Ejaculatory incompetence	4	4

Premature ejaculation overwhelmingly dominates the other categories among the disorders of men. Rapid ejaculation is no detriment to reproduction and seems to be the usual case in the animal world (3) and among many men (4). It has been suggested that premature ejaculation in human males may be the result of early conditioning by prostitutes and other sexual contacts designed for self-gratification rather than gratification of a partner (2). The older men in the Masters and Johnson pool of patients had had substantial contact with prostitutes. Far fewer young men today seem to have initial sexual experiences with prostitutes than was true in the past (at least among college students I have contact with). In this population, premature ejaculation seems merely to be another expression of the hyperactive sexual status of the younger man (similar to his capacity for easy arousal and multiple orgasms) rather than a result of faulty conditioning. Active processes, including greater sexual experience and the reinforcement of delayed ejaculation as a good thing, lead sexually successful men to adapt a pattern of response that provides greater gratification for their partners. Aging undoubtedly helps in this process. Delaying response is actually a process of learning a new behavior or becoming deconditioned to what is natural. Unfortunately, the slow learner or especially hyperactive man may experience feelings of inadequacy.

Information about the nature of sexual response and instruction in sexual technique has been helpful to many of my correspondents and to others I have seen in consultation. However, immense problems are posed in treating people who are without regular sexual partners or who have sexual partners who are unable to cooperate in a treatment plan, situations that arise in a youthful population. The dilemma is clear. It is important that young people who are sexually active learn to function well if their hopes for good functioning in the future are to be realized. However, the conditions necessary for helping are often not present.

Lest I sound pessimistic, I should point out that I have been struck by the sensitivity and caring expressed

in letters sent to me by partners of individuals with sexual problems. There is often an openness and willingness to help that is almost astounding, and only one letter indicated dissolution of a relationship because of sexual difficulties.

Two recent articles have indicated that increased sexual freedom has created problems for some individuals (5, 6). A "new impotence" based on the demands of women for sexual gratification has even been suggested. The data I have presented do not support this suggestion. Not one case emerged in which the female partner was cited as the cause of a man's problems. The following excerpt from a letter summarizes the attitudes of the writers far better than my descriptions:

> My boyfriend and I have been dating for three years. We just started having sexual intercourse the past two months. Up until this time we petted to orgasm. The problem now is that my boyfriend has his orgasm almost as soon as he enters. He gets very upset and feels that I am getting nothing out of it. I want to be able to help him last longer—for both of us. I'm afraid if I can't, he'd be more satisfied and under less pressure to "perform" if we reverted back to petting. I would appreciate any advice so I could help him and our sexual relationship.

Before we attribute symptoms to current social mores, we might best acknowledge that there will always be individuals who function well and those who will function poorly. The manner in which the less able choose to present their inadequacies will always be in the language and mode of the time they live in, and this does not necessarily indicate anything about the frequency or prevalence of a condition. Furthermore, the interest of the helping person also reflects current trends and exerts an influence on the formulation of the problem. In this era of acknowledgement of the importance of adequate sexual functioning, we can expect more concerns about this aspect of human interaction to be voiced by both patients and clinicians.

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DISCUSSION

D.K. KENTSMITH, M.D. (Omaha, Neb.)—Within the past 100 years, methods of obtaining information about human sexual behavior have been varied and often unique. These data collection methods have included case histories, questionnaires, interviews, self-reports, and direct observation.

The case history is a pathological approach in which a patient's history becomes a measure of what is abnormal. Freud, Havelock Ellis, and Krafft-Ebing were pioneers in the use of this method, and their case histories have been rich resources in understanding abnormal human sexual behavior. The major defect of this method is its lack of understanding of what is normal.

Some of the other methods have attempted to deal with this problem. The questionnaire, which was first used by Exner (1) in 1915 to obtain sexual information, is probably the least threatening and easiest to administer. The interview, either guided or unstructured, is a reliable and well-known technique. Beginning early in this century, Hirschfield (2) and then, later and more extensively, Kinsey and associates (3) used quite structured and well-designed interviews that provided some of the most complete and extensive studies in the area of human sexuality.

Probably the most reliable and accurate attempts to gather information on sexual behavior to date have been the classic physiological studies by Masters and Johnson, Fox and Fox (4), and Hellerstein and Friedman (5) using actual observation of sexual function in a normal group of people. The data collection methods I have described vary widely in their reliability and accuracy, with direct observation and measurement of physiological function being the most reliable.

The method Dr. Werner has chosen, voluntary self-report in letters to a newspaper column, must be viewed with caution, and any generalizations made must be limited to the group studied.

One must also be critical of Dr. Werner's definition of terms. It is difficult to see how Masters and Johnson's precise operational definitions of sexual dysfunction could be so easily abstracted from the students' letters, especially since this method does not afford the opportunity for even the simplest clarification.

However, if we can accept these technical problems, the findings of this study do add to our understanding of sexual functioning in a group of college students. Dr. Werner has added information supporting the hypothesis of an evolutionary survival value in premature ejaculation. His observations lend support to the theory that this neurophysiological phenomenon is an inherent, genetically programmed sequence of events rather than the result of faulty conditioning.

It is painfully apparent that an attempt to generalize Masters and Johnson's therapy technique is an acute need for young, single adults. Also, the large number of sexual concerns relating to physiology and anatomy expressed in the letters clearly illustrates that there is a continuing need for education in this area, despite our rather dramatically increased openness about sexuality.

One must be cautious in comparing the small number of women with sexual dysfunction in this study to the larger number studied by Masters and Johnson. However, the striking difference in the percentage of these women who experience situational orgasmic dysfunction raises several questions, such as whether there is increased peer pressure to experience orgasm in college women.

Dr. Werner has shown how an open and nonthreatening method can be used to obtain information on general and personal concerns. While the method has many sources of potential error, especially that of investigator bias, it does provide a general means of sampling the concerns expressed by a group of people.

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Desensitization Therapy in Impotence and Frigidity: Review of the Literature and Report of a Case

BY BURTON S. GLICK, M.D.

The author reviews the available scientific literature on the use of behavior therapy in the treatment of impotence and frigidity, noting that there is a dearth of published information in this area. Behavioral techniques are described, and a case of impotence and anhedonia that responded well to relaxation/desensitization therapy is presented. The author concludes on the basis of his clinical experience and review of the literature that desensitization has definite value in the treatment of impotence and frigidity.

DESPITE THE RECENT burgeoning popularity of behavior therapy, published information on its use in treating the two most common sexual dysfunctions (impotence and frigidity) is sparse. A review of the literature in English revealed reports of only 13 cases of impotence and 33 cases of frigidity treated with behavioral techniques. This dearth of information is probably related to the intimate nature of the subject matter and to the influence of older analytic orthodoxies. This paper will present a summary review of the literature and a description of behavioral treatment in a case of impotence.

DESCRIPTION OF THE TECHNIQUE

Behaviorists believe that responses inimical to the development of anxiety will result in abolition of anxiety by either inhibition or extinction (probably the former). Consequently, there will be a loss of anxiety-rooted symptoms, and the individual will have an opportunity to learn or relearn healthy, adaptive patterns of behavior. Among these anxiety-inhibiting responses are the following:

1. Deep muscular relaxation. This can be achieved by specific training methods such as Jacobson's progressive relaxation (1), by hypnosis, or by drugs like intravenous sodium methohexital (Brevital).

2. Sexual responses. From the large repertoire of possible sexual activities, the therapist instructs the patient to perform only those activities which he/she desires and which are not likely to result in anxiety or failure.

3. General assertive responses. These responses include behaviors such as speaking up to one's boss, expressing counterviews firmly, or saying no to an unreasonable request.

Relaxation is an integral part of Wolpe's (2) method of systematic desensitization, also known as reciprocal inhibition. Although desensitization was originally designed specifically to treat phobias, it soon became apparent to Wolpe and others that the technique was also applicable to certain sexual disorders. These disorders may be considered phobic responses because they arise from anxiety.

Briefly, systematic desensitization involves presenting the patient, who is in a state of deep muscular relaxation, with a series of imaginary sexual scenes that he is to visualize as vividly as possible. Hypnosis may be used as an adjunct to achieve greater relaxation and more graphic visualization. The imagined scenes proceed gradually from the most innocuous (e.g., talking to a member of the opposite sex) through intermediate stages (engaging in various sexual preliminaries) to the most fearful (actual sexual intercourse). These graded scenes constitute the "phobic hierarchy." The patient immediately signals the

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therapist (usually by moving a hand or finger) if he experiences anxiety during the visualization. When this happens, a previous nonthreatening scene is presented, and the conditioning process resumes its hierarchical course. No scene may be introduced until the patient has visualized all prior scenes in the hierarchy without anxiety. Thus inhibition of the inappropriate, maladaptive neurotic reaction is presumably achieved and the patient is conditioned to respond with relaxation to stimuli that previously evoked anxiety. The expectation is that the patient's accomplishments in the therapeutic milieu will generalize to his real life.

BEHAVIORAL TREATMENT OF FRIGIDITY

The largest series of cases of frigidity treated with behavioral techniques was reported by Lazarus (3), who used relaxation and desensitization to treat 16 cases of "recalcitrant and persistent frigidity, many of which had failed to respond to the usual run of psychiatric techniques." His anxiety hierarchies depicted increasing degrees of sexual intimacy, as is customary in this technique. After a mean of 29 desensitization sessions, 9 of his 16 patients (56 percent) were regarded as sexually adjusted. Lazarus' standards for success were high, requiring that the patient almost always reach orgasm. Whenever possible, patients' husbands were interviewed separately and encouraged to express their opinions concerning the outcome and effect of therapy. Lazarus' follow-up inquiries strongly suggested the durability of the method, and he concluded that no other therapeutic approach could achieve comparable results in the treatment of chronic frigidity.

Madsen and Ullmann (4) used a variation of this technique in which the husband verbally presented the hierarchy items to his wife during therapy sessions. Only one of the seven women they treated had ever experienced orgasm by any technique. They used the relaxation/desensitization method and described their results as "generally favorable." However, with the exception of one case, the authors did not present either their criteria for success or the extent of their failure.

Brady (5) modified Wolpe's desensitization method by using subanesthetic doses of intravenous sodium methohexital to induce rapid, deep muscular relaxation and freedom from anxiety just before and during each therapy session. The patient's husband was also interviewed during the anamnesis, and the nature of the treatment was explained to the couple. Brady obtained "marked improvement" in four out of five cases of severe chronic frigidity in a mean of 11 sessions. The patient's sexual adjustment at the end of treatment was corroborated, if possible, by an interview with her husband.

Brady's criteria for marked improvement were fairly stringent and included pleasurable sexual activity, without anxiety, that culminated in orgasm at least some of the time. Follow-up of the improved patients from three to eight months after the conclusion of therapy revealed that all of them had maintained their improvement. Brady believed that severe frigidity, characterized by extreme feelings of anxiety, disgust, or anger, sometimes accompanied by physical pain, is quite refractory to treatment by either direct counseling techniques or intensive psychotherapy.

Haslam (6) described two cases of severe psychogenic dyspareunia in which a variant of systematic desensitization was used with rapid and entirely successful results. Size-graduated glass bougies were inserted in the patient's vagina and maintained in position by the therapist at first and then by the patient. During this procedure, the therapist reassured the patient and encouraged her to relax. In both cases, intercourse soon became "normal, satisfactory, and pleasurable." These terms were not specifically defined, nor did Haslam report the number of failures (if any) with this approach. He stated that relapse was most improbable in that the "anxiety-relieving properties of sexual responses could be predicted to support and continue to prevent any recurrence once intercourse was being enjoyed." It goes almost without saying that the particular nature of this technique would give pause to the vast majority of psychiatrists in this country, even those willing to try behavioral methods.

Kraft and Al-Issa (7), Ince (8), and Dengrove (9) each reported a single case of frigidity successfully treated with relaxation and desensitization.

BEHAVIORAL TREATMENT OF DYSFUNCTION IN MEN

The largest series of cases of impotence treated by behavioral techniques was reported by Wolpe (2), who used desensitization, sexual responses, and assertive responses (singly and in various combinations) in the treatment of eight cases of impotence. Five of the eight were considered "apparently cured" and three were "much improved" at the conclusion of therapy. The mean length of therapy was 9.8 months, with a mean of 30.6 interviews. However, Wolpe gave no consistent criteria for cure or improvement. He provided follow-up data for three of the cases, ranging from six months to two years and eight months after therapy ended. In each instance the patient maintained his improvement.

Dengrove (9) briefly described three cases of impotence successfully treated with systematic desensitization. He did not indicate specific criteria for recovery, nor did he mention any therapeutic failures. Ince (8) and Lazarus and Rachman (10) each described a single case of impotence successfully treated with systematic desensitization.

Case Report

The following is a brief illustrative history of a case of impotence I treated with relaxation and systematic desensitization.

The patient, a 36-year-old lawyer, was truly unusual in that he had never masturbated—he had never tried to nor wanted to. In fact, he had never experienced orgasm and ejaculation while in the conscious waking state (including periods of sexual activity with his wife), although he had occasional nocturnal emis-

sions. He had been married for six years to a sexual naïf who enjoyed sex and was unaware of his ejaculatory flaw. He had never discussed this with her. He found all aspects of sexual relations "repulsive, disgusting, and dirty." He was "afraid" of ejaculation and "dreaded" intercourse. He obtained erection with considerable difficulty and often not at all. During his infrequent coitus, he always lost his erection within three minutes. He had been in analytic psychotherapy for two years, twice weekly, with a worsening of his symptoms.

Sixty-eight relaxation/desensitization sessions over a two-year period produced exceptionally good results, but unfortunately the patient did not achieve orgasm. He was eventually able to engage in all the forms of sexual expression that had originally evoked his revulsion, including nocturnal emissions, manual stimulation of his wife's vagina, cunnilingus, and intercourse. His affect was rather neutral at first, but he later felt a positive sense of enjoyment of these activities. He became capable of continuing intercourse for as long as 10 minutes and experienced greater physical sensation in his penis than he had before.

This is as far as conditioning therapy has been able to take the patient to date. It may be that he will never experience orgasm in the conscious, waking state, but the improvement in his overall sexual performance has been nothing short of remarkable.

I have treated three other impotent patients with relaxation/desensitization, combined with hypnosis in two cases. My indices of improvement were the ability to obtain and maintain erection, the duration of intercourse, the frequency of successful intercourse, and the patient's degree of enjoyment. At the conclusion of therapy, one of these patients was apparently cured, one was moderately improved, and one was slightly improved.

CONCLUSIONS

The literature seems to indicate that behavior therapy has considerable merits in the treatment of sexual disorders. My results in treating impotence tend to confirm this conclusion. The behaviorists who write on the subject are in almost universal accord that behavior therapy (encompassing desensitization, sexual responses, and assertive responses) is the treatment of choice in frigidity and impotence and that the usual psychoanalytic and psychotherapeutic techniques are vastly inferior by comparison. Whether those skilled in the analytic method would agree with this position is a point for consideration. Obviously, the behaviorist is likely to treat only the therapeutic failures of the analytic school rather than its successes.

Among the behaviorists whose work I reviewed for this study, only Rachman (11) urged a degree of caution. He stated that the results of behavior therapy in sexual disorders "have been promising .... Perhaps the best attitude at this time is one of cautious optimism."

It is unfortunate that six of the nine clinical papers I have reviewed (4, 6, 7–10) revealed only their successful outcomes without indicating whether there were patients who did not fare well with behavior therapy. However, the three studies that took into account possible therapeutic failures as well as successes (2, 3, 5) reported high improvement rates (56 to 100 percent).

Despite the rather affirmative statements of some authors (3, 6, 8) about the permanence of results, I think that Dengrove (9) has some very wise things to say. He stated that the behavioral approach "presupposes a sexual partner who is willing to go along with the treatment as outlined, who is patient and understanding .... Without an understanding and cooperative spouse it hardly seems worthwhile attacking the problem at all" (pp. 52, 54). One of my cases affirmed this observation. Understandably, many instances of sexual disorders are closely allied to severe marital discord. It would be only logical to assume that desensitization therapy for patients in discordant marriages would result either in direct failure or quick relapse, thus lowering general improvement rates.

Despite the reservations I have mentioned, I am led to conclude on the basis of my review of the literature and my own clinical experience that desensitization therapy is of definite value in the treatment of frigidity and impotence. I feel that psychiatrists would do well, for themselves and their patients, to master this method.

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Short-Term Treatment of Sexual Problems: Interim Report

BY JON K. MEYER, M.D., CHESTER W. SCHMIDT, JR., M.D., MARY JANE LUCAS, R.N., AND ELAINE SMITH, R.N.

Of 52 couples requesting treatment for sexual disorders, 16 were treated in accordance with the protocol of Masters and Johnson except that most were seen once a week for 10 or more weeks rather than daily for a briefer period. The treatment results were less successful than those obtained by Masters and Johnson. The authors believe that the successes of this approach nonetheless suggest a need to reevaluate the degree to which sexual problems may be conditioned responses. They also stress the need for specifying the degree of improvement among nonfailures for purposes of comparison and follow-up.

THE EXISTENCE OF PROGRAMS for the evaluation and treatment of sexual disorders is largely due to the courage and innovativeness of Masters and Johnson and to the professional and public impact of their work.

Their earlier work on the anatomy and physiology of human sexual response (1) led to the reexamination of such long-standing concepts as vaginal versus clitoral orgasm. Their later work (2) systematized and popularized short-term behavioral techniques for dealing with common sexual disorders. This has posed other questions for investigation, including the following: 1) the degree to which sexual disabilities occur independently of psychiatric conditions, 2) the etiologic contributions of neurosis or character disorder, and 3) the efficacy of short-term techniques that make no attempt to resolve internal conflict. In addition, we must weigh very practical issues related to cost-effectiveness. The possibility of rapid, permanent reversal of sexual problems in close to 80 percent of patients has great appeal.

Thus, there are both practical and theoretical issues in any examination of the psychological characteristics of sexually troubled patients and the outcome of directive, short-term treatment techniques. Masters and Johnson have pointed to the need for other workers to confirm their results (2). This obvious need, and the absence of other series, prompted the preparation of an interim report of our ongoing work at the Sexual Behaviors Consultation Clinic of Johns Hopkins University.

Revised version of a paper read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

The authors are with the Department of Psychiatry and the Sexual Behaviors Consultation Unit of the Johns Hopkins University School of Medicine, Baltimore, Md. 21205, where Dr. Meyer is Assistant Professor of Psychiatry and Surgery, Dr. Schmidt is Associate Professor of Psychiatry, and Mses. Lucas and Smith are Instructors in Psychiatry. Dr. Meyer is also Director of the Sexual Behaviors Consultation Unit, Dr. Schmidt is Associate Director, Ms. Lucas is Assistant Director, and Ms. Smith is senior staff member.

METHOD

We analyzed diagnoses (sexual and psychiatric, with psychiatric symptoms or traits as a separate category) and other significant factors of patients we saw between November 1971 and December 1973. These couples (most of whom were self-referrals) sought consultation for a self-designated "primary" sexual problem rather than more generalized psychiatric symptomatology. Some couples expressed a preference for treatment "like Masters and Johnson."

Characteristics of the Consultees

The 52 couples we screened showed a bimodal distribution in the Hollingshead (3) classes as follows: class I, 33 percent; class II, 36 percent; class III, 6 percent; class IV, 23 percent; and none in class V (2 percent of the subjects were unclassifiable). This distribution was probably related to the clinic's dual-fee structure.

Diagnoses were assigned very carefully. Sexual diagnoses were limited to those conditions usually considered responsive to direct short-term treatment—impotence, premature ejaculation, ejaculatory incompetence, dyspareunia, anorgasmia, vaginismus, and nonspecific sexual withdrawal. Paraphilias were considered psychiatric diagnoses. Two levels of manifest psychiatric problems were distinguished: symptoms and/or character traits, and full-blown neurosis, character disorder, or psychosis. A diagnosis of neurosis, character disorder, or psychosis was not assigned unless there was clear indication of syndromes that met the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (4). However, isolated symptoms or morbid personality traits were noted, even when we considered them insufficient to establish a diagnosis.

Considerable effort was made to avoid the logical inconsistency of using sexual and related symptoms to diagnose both a sexual disorder and a neurosis. For example, a patient with obsessive concern about impotence was listed only as impotent unless there was clear evidence of obsessive thought in other spheres such as nonsexual social interaction. When patients had both diagnoses and symptoms or traits, diagnoses were considered

preemptive. However, symptoms not contributory to the diagnoses were categorized separately.

Premature ejaculation and impotence were the most frequent diagnoses among the male consultees, with 21 percent and 19 percent, respectively, of the men falling in these categories. Obsessive-compulsive personality, diagnosed in 17 percent of the consultees, was by far the most frequent psychiatric diagnosis. Of the 52 women, 52 percent were diagnosed as having anorgasmia of varying degrees (orgasmic failure with coitus only or failure with both coitus and masturbation). Depressive neurosis and hysterical neurosis were common psychiatric diagnoses, occurring in 15 and 31 percent of the consultees, respectively. There was no observable socioeconomic trend in either single diagnoses or diagnostic combinations.

This group of lower-middle to upper-middle class individuals seeking consultation for sexual disorders showed a wide variety of sexual and psychiatric diagnoses and psychiatric symptoms or traits. There were several observations that were significant (see table 1). A sexual diagnosis alone was made in only 7.7 percent of the men and 19 percent of the women. In 27 percent of both men and women, both sexual and psychiatric diagnoses were made. In 25 percent of the men and 19 percent of the women, the psychiatric diagnosis was the only diagnosis, and in 67 percent of the men and 62 percent of the women, psychiatric diagnoses or symptoms or traits contributed to the problems for which help was sought.

TABLE 1
Diagnostic Classification for 52 Consultee Couples

Classification	Men		Women	
	Number	Percent	Number	Percent
Sexual and psychiatric diagnoses	14	26.9	14	26.9
Sexual diagnosis and psychiatric symptoms and/or traits	4	7.7	6	11.6
Sexual diagnosis only	4	7.7	10	19.2
Psychiatric diagnosis only	13	25.0	10	19.2
Psychiatric symptoms and/or traits only	4	7.7	2	3.9
No diagnoses and no symptoms and/or traits	13	25.0	10	19.2

Characteristics of the Treatment Group

Several factors excluded some of the 52 couples from short-term treatment, e.g., unwillingness to commit time or financial resources, anxiety about treatment, or the presence of neurotic disorders with severe classical symptomatology that we judged to be more appropriate for psychotherapy or psychoanalysis. The 16 couples we treated were highly selected, as was the group treated by Masters and Johnson (2).

The average age of the 16 men in the treatment group was 35, with a range of 23 to 52. The women's ages ranged from 23 to 53, with an average age of 33. All of the treated individuals were Caucasian. The couples had been married an average of 10 years, with a range of 1.5 to 29 years. The majority were in Hollingshead (3) classes I and II (31 and 50 percent, respectively); 6 percent were in class III and 13 percent in class IV. The chief female complaints related to lack of sexual satisfaction—often lack of orgasm in coitus. Male complaints were of performance inadequacies, usually impotence or inadequate ejaculatory control. In 3 of the 16 couples, the complaints included threats of separation.

Forty-four percent of the men had sexual diagnoses, as did 87 percent of the women (for the entire group of consultees, these figures were 42 percent and 58 percent, respectively). In terms of psychiatric diagnoses or symptoms or traits, this trend was reversed: 75 percent of the men versus 63 percent of the women. For the consultees, these percentages were 67 and 62, respectively. The group treated showed somewhat higher levels of pathology than did the larger group of consultees.

TREATMENT RESULTS

The 16 couples were seen by two dual-sex teams of therapists (J.K.M. and M.J.L., C.W.S. and E.C.). We followed the protocol of Masters and Johnson (2) except that 13 of the 16 couples were seen weekly rather than daily, for a total of 10 or more sessions. A factor in the choice of a weekly program was our experience with a 10-week symptom-focused treatment for psychosomatic problems (5). The weekly format is now an accepted technical variation in most centers. When treatment ended, we were available by telephone or for consultation at any time. We attempted a personal posttreatment follow-up at 6 weeks, 6 months, 1 year, 18 months, etc. for all cases (average follow-up was 7 months). Patients were reevaluated by their treatment team at follow-up.

Table 2 summarizes the data by couple for psychiatric and sexual pathology and initial and follow-up results. "Marked improvement" indicates apparent complete relief of the targeted sexual problems, "improvement" denotes substantial gains but not complete relief, "equivocal improvement" indicates some minimal positive change in the sexual symptoms, and "no improvement" means there was deterioration or no change.

Outcome: The Couple as the Unit

Judgments of treatment efficacy were first based on the couple as a unit, an approach rationalized by the treatment method, which presupposes shared problems and views the couple as the "patient." From this perspective, 4 of the 16 couples (25 percent) showed marked initial improvement. For couples, "marked improvement" indicates that the primary sexual dysfunction in both partners was relieved. There was improvement in 25 percent of the couples (N=4) and equivocal improvement in 31 percent (N=5). No improvement or deterioration was noted in 19 percent of the partnerships (N=3).

As is shown in table 2, 3 of the 4 couples with initial marked improvement showed similar levels of functioning at follow-up. (The fourth case was lost to follow-up.) Two of the 4 improved couples maintained their improvement at follow-up; there was decreased ejaculatory con-

TABLE 2
Diagnostic Classification and Initial and Follow-Up Results for 16 Treatment Couples

Couple Number	Sexual Diagnosis		Psychiatric Diagnosis		Psychiatric Symptoms and/or Traits		Results*	
	Man	Woman	Man	Woman	Man	Woman	Initial	Follow-up
1	no	yes	yes	no	no	yes	MI	MI
2	yes	no	yes	no	no	no	MI	MI
3	no	yes	yes	no	no	no	MI	MI
4	yes	no	yes	no	no	no	MI	U
5	yes	yes	no	yes	no	no	I	I
6	yes	yes	no	yes	no	no	I	I
7	yes	yes	yes	no	no	no	I	EI
8	no	yes	no	yes	no	no	I	EI
9	no	yes	yes	no	yes	no	EI	EI
10	yes	yes	yes	no	yes	no	EI	EI
11	no	yes	yes	yes	yes	yes	EI	NI
12	yes	yes	yes	yes	no	no	EI	NI
13	no	yes	yes	yes	yes	no	EI	NI
14	no	yes	no	yes	yes	no	NI	NI
15	no	yes	yes	yes	no	no	NI	NI
16	no	yes	yes	yes	no	no	NI	NI

*MI = marked improvement, I = improvement, EI = equivocal improvement, NI = no improvement or deterioration, U = unknown (lost to follow-up).

trol in the third and return of dyspareunia in the fourth. Among the 5 couples who showed equivocal improvement, 2 maintained the general gains and 3 deteriorated to pretreatment levels. None of the 3 couples initially deemed failures improved over time.

Outcome: The Individual as the Unit

Seven men and 14 women in the treatment group manifested sexual disabilities. Five of these men showed initial marked improvement and 2 showed equivocal improvement. At follow-up, 3 of the 5 markedly improved men maintained high levels, 1 dropped to the improved category, and 1 could not be reached. Of the 2 men with equivocal improvement, 1 maintained that level and the other dropped to a pretreatment level of functioning. Of the 14 women with sexual disability, 8 showed no initial improvement, constituting the major reservoir of failure. Two showed initial marked improvement, 1 showed improvement, and 3 were rated equivocal. At follow-up, the 2 women with marked improvement maintained that level. One individual from each of the next two categories (improved and equivocally improved) dropped by a level at follow-up. Individuals without a specific sexual disability at the start of treatment remained disability-free during treatment and follow-up.

DISCUSSION

Psychiatric Problems Associated with Sexual Difficulties

In this series of patients, we found a high incidence of associated psychiatric difficulty in patients requesting treatment for common sexual problems. These results, however, are not strictly comparable to others in the literature. For example, Maurice and Guze (6), using different criteria with patients in their second week of treatment at the Reproductive Biology Research Foundation in St. Louis, Mo., reported that one fourth of the men and one-third of the women in the sample qualified for psychiatric diagnoses. At the other end of the spectrum, O'Connor and Stern (7) reviewed 96 psychoanalytic clinic patients with sexual dysfunction and found that all of them had both psychiatric and sexual diagnoses.

Our facility at Johns Hopkins falls somewhere between O'Connor and Stern's psychoanalytic clinic and the Reproductive Biology Research Foundation in its approach. Since diagnosis involves discrimination, even in the choice of criteria, treatment results reflect the bias of the diagnostician. In addition, however, it seems likely that patient self-selection is operating in line with the known orientation and services of a particular treatment facility. Patients appearing at a psychoanalytic clinic may do so out of a sense that analysis will best fit their needs. Patients appearing at the Foundation in St. Louis may have the opposite feeling.

Patient Selection for Short-Term Directive Work

Masters and Johnson (2) indicated that exclusions from treatment were based on the presence of psychosis, the "psychoneurotic" being acceptable. In 1973, they seemed to indicate some increased concern about the prevalence of neuroses and their potential for complicating treatment (8). Kaplan and Kohl (9) outlined some adverse reactions, emphasizing careful assessment not only of the sexual disability but also of the psychiatric status. They suggested exclusion of patients "in a depressed or highly conflictual state . . . not primarily reactive to the sexual problem . . ." and noted "relatively rare" instances in which the sexual symptom constitutes a major defense.

In our experience, sexual disability was often noted during evaluation and treatment in a context of neurosis

and/or character disorder. Often the issue had less to do with the absence of such problems than the degree to which they might be ignored in short-term, focused treatment. For example, a patient we saw with anorgasmia, obsessive fear of loss of bowel control, and agoraphobia was felt to be better suited for psychotherapy. On the other hand, a minimal character disorder or a neurotic symptom that was mildly inconvenient at the outset of treatment often became more marked during treatment, but not necessarily in a way that interfered with the Masters and Johnson protocol. In most cases, the sexual symptom was acceptable at some level as a compromise between more adequate function and the hazard of greater anxiety or failure. The issue was how overdetermined such patterns might be.

Treatment Experience

Our experience indicates that short-term behavioral treatment of sexual disorders may be wholly or partially successful in a number of instances and that substantial success tends to be maintained at follow-up. In other cases, focused treatment works less well and the minimal gains seem subject to deterioration. In this series, it was easier to achieve and maintain control with male performance problems than with female difficulties (see table 2). There was a tendency for higher degrees of nonsexual psychopathology (i.e., cases 1–8 versus cases 9–16 in table 2) to be associated with less initial improvement and poorer maintenance of that improvement at follow-up.

Over the course of treatment, appreciable links became manifest among the sexual problems, other symptomatic material, and nonsexual behavior patterns. The symptoms and/or traits, seemingly of minor significance during evaluation, often contributed materially to difficulty during treatment. In some instances, neurotic and character formations related to the sexual disability seemingly emerged de novo during treatment. Transference distortions of the therapeutic relationship and goals were virtually universal, serving to make the presenting sexual disability more comprehensible. It must be emphasized that we proceeded in a directive, educative, goal-oriented fashion in treatment and did not seek to elicit transference, genetic, or conflictual material—such material intruded itself into the ongoing work. Follow-up to date suggests that improvement in some cases may be thought of in the framework of a transference cure, related to overwhelming superego restrictions and at least partially dependent on the presence of the therapists.

Categorization of Treatment Results

Masters and Johnson (2) reported their treatment results in terms of failure rates, with an overall initial failure rate for marital units of 18.1 percent. Initial failure rate "is defined as indication that the two-week, rapid-treatment phase has failed to *initiate* reversal of the basic symptomatology of sexual dysfunction . . ." (emphasis added). Our initial failure rate for marital units was 19 percent, which is almost equivalent to Masters and Johnson's. The failure rate alone, however, did not describe the varying degrees of improvement within nonfailure units.

It seems necessary for purposes of follow-up and later comparison to specify the degree of improvement among nonfailures. While no follow-up figures are available from Masters and Johnson for marital units, our 7-month follow-up failure rate was 37 percent, the new failures being couples who showed only equivocal initial improvement.

Our success rates for dysfunctional individuals, where the improvement of one partner did not blur the failure of the other, were less positive overall than those reported by Masters and Johnson (2) and were similar to those from other psychotherapeutic modalities (10). It should be noted that the success of Masters and Johnson with primary impotence, secondary impotence, "random orgasmic inadequacy" (in women), and aging men and women was less impressive than their overall treatment results. Contributing to their better overall results were higher success rates in such categories as premature ejaculation, ejaculatory incompetence, primary orgasmic dysfunction, and coital orgasmic inadequacy (2, pp. 351–369). Secondary impotence and random orgasmic inadequacy were highly represented in our series and may account for our less positive results.

CONCLUSIONS

Our current task is to review a treatment modality that is gaining increasing acceptance in medicine and psychiatry, exploring its limitations and strengths, its indications and contraindications, and integrating it within the general body of psychiatric experience. It has seemed important to do our patients a service in terms of increased cost-effectiveness without unproductively simplifying complex intra- and interpersonal issues.

In the majority of our cases, sexual disorders were accompanied by symptoms of psychiatric disturbance. Treatment and follow-up experience indicated that the sexual disability often could not be disentangled from intrapsychic dynamics which limited the degree of mechanical rehabilitation and the capacity for subjective intimacy. Experience in conventional treatment of neurotic problems, however, is often the obverse, i.e., most ramifications of the neurosis may yield, while the sexual dysfunction tenaciously repeats itself.

Certain aspects of sexual problems were usually more or less allied with neurotic or character problems, but with varying amounts of freedom in the alliance. The strength of this alliance was a crucial factor in short-term outcome. Other aspects of sexual problems seemed conflict-free, representing misinformation, habit, poor technique, and more superficial problems in relationships. The fact that the Masters and Johnson techniques were strikingly successful in certain instances indicates the necessity for a reevaluation of the degree to which sexual problems may be culturally determined or become secondarily autonomous (i.e., persisting although they no longer serve a defensive function). Sandler and Joffe (11)

refer, for example, to psychological structures originating out of conflict but persisting even though the original impulses are no longer operative in the same way. They suggest that problematic structures of this type are amenable to behavior therapy.

It is important to recognize that a variety of modalities are useful in the treatment of sexual problems, depending on the individual and the disability. Rather than an a priori set toward one particular treatment mode, dynamic or behavioral, the specific technique should be judiciously selected according to individual capacities, symptomatology, character traits, lifestyles, motivation, and therapeutic goals.

On the basis of accumulated clinical experience, perhaps the most one can say at this time is that any sexual disability has two components—a neurotic component related to internalized conflict and a habitual conditioned response mode related to repeated partial gratifications. It may turn out that the treatment of choice in the rehabilitation of sexual disability will be a tandem approach to both aspects of the problem. As Kestenberg (12) observed, most patients suffering from a sexual disability cannot be completely educated in sexual functioning until relief of conflict has rendered them educable. But standard psychotherapies do not offer direct education; this is the province of directive techniques.

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DISCUSSION

JOHN F. O'CONNOR, M.D. (New York, N.Y.)—Dr. Meyer and associates present an informative review of the treatment of sexual disorders at Johns Hopkins using the Masters and Johnson protocol, modified by extending the time frame. Their study of the total group of consultees presents some interesting findings, and their methodology is excellent.

Sexual therapy is quite new to American psychiatry, although there are reports of the results of hypnosis dating back to the late 19th century and of behavioral therapy from the late 1940s. The vast majority of work in this field, however, postdates Masters and Johnson's pioneer effort. Five years ago, their treatment was considered a fad by many, but a more serious approach is now being taken. It is most encouraging that many of those who are using the Masters and Johnson technique are validating and publishing their results. This introspection and willingness to deal with failures have added credibility to the field.

In the psychiatric literature of the past 50 years, sexual disorders were virtually always related diagnostically to severe neurosis and psychosis. Dr. Meyer and associates examined this relationship and found that there are in fact patients who suffer sexual disorders but do not have a definitive psychiatric diagnosis. In our rapid-treatment population at the International Institute for the Study of Human Reproduction at Columbia University, we have an even higher proportion of patients for whom a psychiatric diagnosis cannot be definitively established. Many of these patients are all too "normal." One gets the impression such patients have given up libidinal expression and drive in order to maintain societal (parental) approval. The dysfunction is not seen as an autonomous ego function, but rather as extreme suppression and denial manifested in the psychophysiological sphere that enables the individual to avoid what seems to him to be a catastrophic anxiety. One finds evidence of dysfunction in other areas in these individuals (e.g., career and interpersonal relationships), although this is much more subtly manifested.

In our experience, the Masters and Johnson therapy protocol is by far the most effective to date. It offers many advantages, the most important of which is that it allows both partners to understand in detail which of their interactions are leading to symptom development or maintenance. However, only the middle and upper socioeconomic groups can be treated by this method as it was originally designed because of the large investment of time and money it requires. Dr. Meyer and his coworkers have offered an alternative—Masters and Johnson-type treatment on a weekly rather than daily basis in a clinic with a dual-fee structure.

We look forward to further detailed reports from these authors and others involved in sexual therapy.

Difficulties in Brief Conjoint Treatment of Sexual Dysfunction

BY MELVIN R. LANSKY, M.D., AND CAPT. ADELAIDE E. DAVENPORT, USAF

The authors offered conjoint treatment of sexual dysfunction to an unselected population in a military hospital for one year. Of the 10 couples who requested treatment, 7 were treated by techniques outlined by Masters and Johnson. The couples who completed the treatment exercises improved, and neurotic interactions, presumably resulting from the symptoms, often disappeared. The couples who avoided the exercises had interactional patterns dominated by projection and blame, sadomasochism, and depressive features; typically their marital difficulties were aggravated by the treatment.

THE WORK OF MASTERS AND JOHNSON has made monumental contributions to our knowledge of human sexual dysfunction. These authors and their coworkers have added knowledge about human sexual response (1), developed a treatment program aimed at short-term symptomatic treatment (2, pp. 1–91), and studied the results of treatment in one of the most rigorous evaluation programs ever done (2, pp. 351–369).

With a selected patient sample, their results are impressive. Compared in terms of failure rates after short-term treatment, the overall failure rate for male disorders of all kinds is 16.9 percent and that for female disorders is 19.3 percent. Failure rates after a five-year follow-up are only slightly higher, demonstrating a low reversal rate for therapeutic success and an overall failure rate for all disorders in both sexes of about 20 percent.

But such results apply largely to highly motivated patients who are of relatively high social, educational, and financial status and are relatively free from psychopathology other than symptoms of sexual dysfunction. Almost 90 percent of their sample of 790 patients did not live in St. Louis (the location of the treatment program) and were sufficiently motivated and financially able to make the trip. Seventy-two percent were college graduates, 17.5 percent were physicians, and half of the physicians were psychiatrists.

At the time this work was done the authors were with the Department of Mental Health, Wilford Hall USAF Hospital, Lackland Air Force Base, Tex., where Dr. Lansky was Staff Psychiatrist and Capt. Davenport is a social worker. Dr. Lansky is currently Assistant Professor in Residence, University of California, Los Angeles, Medical School, and Staff Psychiatrist, Brentwood Veterans Administration Hospital, Los Angeles, Calif. Address reprint requests to Dr. Lansky, 3940 Sapphire Dr., Encino, Calif. 91436.

The opinions expressed here are those of the authors and do not necessarily reflect the views of the Department of the Air Force.

No patients other than physicians were accepted unless they were referred from a treatment authority. Most patients had symptoms of sexual dysfunction only. Psychoneurotic patients were accepted; psychotics were not. Both partners had to be interested in reversing the disorder. The couple had to be adjusted to their social community, understand the procedures involved, and, in most cases, had to pay the fee.

One chapter of *Human Sexual Inadequacy* (2, pp. 370–391) is devoted to treatment failures, but, by and large, this is the least satisfactory part of the study. Masters and Johnson demonstrated the effectiveness of their techniques for motivated patients free of psychopathology other than their presenting symptoms, but their discussion of what went wrong in unsuccessful cases is of little help in ascertaining when and for whom such techniques may be of help in an unselected, local population.

Regrettably, literature adding to our knowledge of what goes wrong in treatment failures is hard to come by. Dynamically oriented studies (3, 4) usually point to the dynamics presumed to underlie the sexual difficulty, rather than to the difficulties in treatment itself; more behavioral studies tend to use case material as illustrative of what is being done (5) or to give overall results (6), again without examining treatment difficulties. Studies antedating the work of Masters and Johnson usually do not consider treating the couple as a unit and consequently are of little value in highlighting difficulties in such treatment.

METHOD

This paper reviews a one-year treatment program conducted by a team of cotherapists in a military general hospital in San Antonio, Tex. Patients were active-duty and retired military personnel and their families. A total of 10 couples presented themselves for treatment; 8 were offered treatment for symptomatic sexual difficulties, and 2 were treated conjointly in psychotherapy sessions for marital disharmony. The sample differed from that of Masters and Johnson in several important ways. Treatment was local and without cost, and any couple requesting treatment was treated. Patients tended to be of lower social, economic, and educational status—8 of the 10 men were enlisted men.

Treatment consisted of three to four hourly sessions a week for two to four weeks. At a preliminary session, couples were told not to embark on treatment unless they could attend all sessions and devote a large amount of time each evening to prescribed exercises. Difficulties

that could be anticipated were discussed in advance. These included job demands, children, other obligations, and anxieties about the treatment itself. Each spouse was seen once individually by each cotherapist; thereafter, cotherapists met only with the couple as a unit.

The treatment technique, similar to that outlined by Masters and Johnson, stressed anxiety reduction, instruction by cotherapists, and communicative openness. The couples started by alternately giving and receiving pleasure, the "pleasured" partner asking for what he or she wanted, other than genital or breast stimulation or intercourse, which were forbidden. Intercourse at times other than the exercises was discouraged. Other activities were added when pleasuring experiences were consolidated, when communication had started, and when anxiety was reduced (this often occurred very quickly). These included manual genital stimulation (7) and the squeeze technique (2, pp. 92–115), where appropriate. In cases of premature ejaculation, the couple practiced vaginal containment without movement before they had intercourse. As couples proceeded to intercourse, instruction on various positions was given. Throughout the treatment the cotherapists tried to keep the marital partners out of a performing role and to facilitate each partner's asking for what was wanted and discussing what was disliked. A synopsis of treatment results is given in appendix 1.

DIFFICULTIES

It is striking that virtually no scheduled therapy session was missed by any of the 7 couples. (One couple, designated in appendix 1 as couple H, dropped out when the wife refused treatment.) In the treatment hours themselves there were very few difficulties posed by anxieties over specifically sexual matters: e.g., performance, the exercises, or talking about sexual matters. Active didactic and supportive interventions by the cotherapists were largely successful in reducing anxiety and facilitating communicative breakthroughs. Domination of the hours by conflictual issues aside from sexual matters or the refusal of one or both partners to discuss any matter was ominous for the prognosis.

By far the most striking difficulty was in doing the nightly exercises. A task was assigned each night that was clearly defined in terms of what was to be done and how much time was to be spent. Of the 7 couples in treatment, only couple B did the exercises unfailingly. Those who did the exercises consistently improved symptomatically; no symptoms improved in couples who did not do them. In the latter group, even vigorous interpretation by the therapists and warnings that the couple was avoiding treatment did not reverse the failure to do the exercises.

The cotherapists terminated treatment for couples D and E because several weeks of treatment failed to stop sadomasochistic and depressive trends during treatment hours and because the couple persistently failed to do the exercises. Couple F dropped out of treatment when couples psychotherapy was suggested for the same reasons. Couple G decided to divorce, and Mrs. H refused treatment. Couples I and J decided on couples psychotherapy at the outset. Treatment of couple C was terminated when Mrs. C became suicidal and was hospitalized.

A word must be said about the cotherapists' handling of difficulties in the treatment. Since the couples had agreed in advance to make time for therapy sessions and nightly exercises, the cotherapists felt free to inquire about anxiety when exercises were missed or there was difficulty discussing sexual experiences in therapy sessions. Very often an explicit source of anxiety was evident or surfaced easily, but reasons other than anxiety were frequently given for not pursuing the agreed-upon task.

It was not uncommon for couples with sexual dysfunction to have schedules that left them with little time together—children interfering, colds, feeling tired, guests, sudden business, overextended social obligations, and many other excuses were encountered. In each case, the question of avoiding treatment was raised. This focus on opposition to the treatment process, presumably due to anxieties beyond the couples' awareness, has much in common with the focus on resistance in psychoanalysis. Sandler and associates (8) argued that the concept of resistance may be extended to clinical situations other than psychoanalysis.

DISCUSSION

The differences in results of the sample described here and that of Masters and Johnson are striking. Of the 10 couples in our sample, only 2 (couples A and B) left with totally satisfactory results. Even though the sample size does not permit tests of statistical significance, some discussion of the differences is necessary.

1. Treatment was largely based on the technique outlined in *Human Sexual Inadequacy* (2), but the frequency of missed exercises necessitated more emphasis on avoidance of treatment.

2. The effect of the particular therapists on outcome is always open to question, but the therapists had notable success with those couples who did the exercises. In fact, it was striking that all the couples who did the exercises improved symptomatically (even Mrs. C, who became suicidal).

We were most struck with differences between those couples who improved (couples A, B, and C) and those who did not (couples D through H).

The improved group had come for therapy shortly after their difficulties became apparent. Couple A presented after the husband's severe cervical spine injury. Couples B and C came several months after the birth of a child they anticipated would be their last. Interactional patterns that could be called neurotic were observed in these couples, but they were largely referable to difficulties resulting from the symptom. These patterns included inhibition, frustration, overt anxiety, fear of performing, and fear of failure. They were strikingly accessible to discussion, and the neurotic patterns could be seen to be a result of the symptom rather than its cause (9). In striking contrast to the unimproved group,

these couples did the prescribed exercises, albeit with anxiety at times, and all improved symptomatically.

The unimproved group had symptoms that had existed for a long time. Interactions often involved projection, blame, contempt for the spouse, sadomasochistic and depressive features, and a sense of fearing intimacy that the treatment probably aggravated. In each case an "agenda" between the couple became evident; this agenda extended far beyond the symptom or its consequences and the symptom tended to reinforce or justify it. Couple D became involved in a sadomasochistic scenario involving the wife's failure to clean the house. Mrs. E openly rejoiced in her husband's inadequate performance. Mrs. F persistently complained of being used for sexual purposes only. Couple G talked of different financial aspirations and of divorce. Mrs. H appeared only once in order to prove that the sexual difficulties were her husband's fault. Strikingly, none of the couples ever did the exercises, with the dubious exception of couple G, who talked of divorce during their one try. It is quite likely that the prescribed intimacy brought into focus issues that the marriage was organized around avoiding and that the prospect of symptom removal highlighted more general dissatisfaction with the marriage.

These results from an unscreened sample point to the need for therapists to employ powerful techniques for symptom removal in situations and at times when they can be tolerated. The sample we treated is not large enough to warrant definitive generalizations, but it is hoped that future studies will highlight interactional features of prognostic significance that will help to integrate newer techniques into patients' overall treatment.

APPENDIX 1

Synopsis of Results of Conjoint Treatment of 10 Couples

Couple A: Both mid-20s. Husband referred for impotence presumably due to a cervical spine injury. Eleven sessions. Missed exercises twice. Totally satisfactory results.

Couple B: Both mid-20s. Premature ejaculation. Eleven sessions. Never missed exercises. Totally satisfactory results.

Couple C: Husband mid-40s with premature ejaculation. Wife mid-30s. Much improvement, but wife became suicidal and treatment was discontinued.

Couple D: Both late 30s. Husband referred for loss of erection in intercourse. Four sessions. Never did exercises. Relationship worse. Symptoms unchanged.

Couple E: Both early 40s. Selective impotence. Seven sessions. Never did exercises. Relationship and symptom unchanged.

Couple F: Both mid-20s. Premature ejaculation (and wife's orgasmic difficulties not identified at outset of treatment). Seven sessions. Never did exercises. Relationship worse. Symptoms unchanged.

Couple G: Mid-20s. Inability to ejaculate (and wife's orgasmic difficulties not identified at outset of treatment). Six sessions. Did exercises once while talking of divorce. Symptoms unchanged. Relationship worse.

Couple H: Both in 40s. Occasional impotence. Wife refused treatment.

Couple I: Both late 20s. Wife had difficulty responding. Elected couples psychotherapy on advice from therapists. Relationship improved. Symptom unchanged.

Couple J: Both late 40s. Sexual problems overshadowed by chronic alcoholism and longstanding marital problems. Couples psychotherapy was offered. Relationship and symptoms unchanged.

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Affective Disorder: Studies with Amine Precursors

BY DAVID L. DUNNER, M.D., AND RONALD R. FIEVE, M.D.

The authors assessed the clinical antidepressant effects of L-tryptophan given alone and in combination with L-dopa in 12 patients with a diagnosis of primary affective disorder. Preliminary results did not demonstrate an antidepressant response when L-dopa was combined with L-tryptophan. Also, the results did not support the catecholamine or biogenic amine hypotheses of affective disorder.

THE PURPOSE of this paper is to relate preliminary clinical results of the administration of amino acid biogenic amine precursors to depressed patients. The use of L-dihydroxyphenylalanine (L-dopa) and L-tryptophan as experimental antidepressant agents is based on the catecholamine hypothesis (and later the biogenic amine hypothesis) of affective disorder, which suggests the possibility that relative or functional deficiencies of central nervous system concentrations of dopamine (DA), norepinephrine (NE), or serotonin (5-HT) may be associated with depressive states (1, 2). The treatment of these depressive states might then be related to increased brain concentrations of these amines.

However, the administration of amines alone would not result in increased brain amine concentrations, since the amines do not cross the blood-brain barrier. Therefore, a treatment strategy has evolved (the "precursor load strategy") based on the ability of precursors of biogenic amines, such as L-dopa and L-tryptophan, to cross the blood-brain barrier (3). Thus in animals and apparently in man, increased amounts of DA in the central nervous system result from administration of L-dopa, and, similarly, concentrations of 5-HT and metabolites are increased during administration of L-tryptophan (4–7).

In previous clinical trials of L-tryptophan in depression, Coppen and associates (8, 9) reported antidepressant effects equivalent to those obtained with electroconvulsive therapy or imipramine. However, these results could not be confirmed by Carroll and associates (10) or Murphy and associates (11).

Several investigators have administered L-dopa to depressed patients, attempting to alter central nervous system catecholamine metabolism in these patients and alleviate their depressive symptoms. Goodwin and associates (12) reviewed these studies and reported on the effects of L-dopa in 16 depressed patients who were studied at the National Institute of Mental Health. They noted that with L-dopa treatment patients with "retarded" depressions had an antidepressant response, while hypomanic-like episodes occurred in depressed patients who had histories of mania (13).

The unipolar/bipolar classification of depression had already been reported (14, 15). This classification separated depressed patients according to their histories of mania or hypomania. Bipolar-1 patients are those depressed patients who have a history of hospitalization for mania; bipolar-2 patients have been hospitalized for depression and have symptoms of hypomania not leading to hospitalization; and unipolar patients have depression only (16). When the L-dopa results from NIMH were reanalyzed using the unipolar/bipolar classification, it was noted that during L-dopa treatment bipolar-1 patients tended to develop manic-like states and bipolar-

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2 patients demonstrated an antidepressant effect, but unipolar patients had no response (17).

Studies in animals suggest that the pharmacological effects of L-dopa include release of 5-HT from its storage sites, resulting in a decrease in 5-HT turnover (18, 19). The rationale for the present study was that the administration of L-dopa and L-tryptophan together might augment the turnover of both DA and 5-HT in brain and result in an antidepressant response, particularly in unipolar patients, who typically do not respond to L-dopa alone.

METHOD

The study was conducted on the metabolic clinical research unit of the New York State Psychiatric Institute. All patients met the diagnostic criteria of Feighner and associates (20) for primary affective disorder and were further described as bipolar or unipolar (16). All patients were studied during the depressed phase, were in good medical health, and voluntarily agreed to participate in these research studies.

The general design was to have a drug-free period of at least 10 days, followed by a placebo period (3 to 7 days), substitution of L-tryptophan (8.4–9 g per day) for 10 to 18 days, addition of L-dopa with a 6- to 13-day period of 4.5- to 6-g daily dose, and a 5- to 7-day postdrug placebo period. The dose of L-tryptophan was held constant during L-dopa treatment.

All medication was given on a double-blind basis, i.e., neither the patient nor the nurse rating team was aware of the periods of active drug administration. Behavioral ratings were performed three times daily by a nursing team trained to use a global rating scale for mood and twice weekly using a structured interview for assessment of symptoms of mania and depression. Clinical antidepressant responses to drug administration were evaluated in the following manner: "nonresponse" indicated no improvement in depression ratings in the last few days of drug treatment; "response" indicated that the patient improved during active drug administration and then had a period of relapse with placebo resubstitution; "equivocal response" indicated that the patient improved with the active drug but failed to have a postdrug placebo rebound depression; "worse" indicated the patient became more depressed during active drug treatment and improved with placebo resubstitution.

Following the double-blind trial, patients were treated in a nonblind manner with either tricyclic antidepressants or monoamine oxidase inhibitors. Behavioral ratings continued during this period of drug administration.

Vital signs were monitored several times daily and routine clinical laboratory tests were repeated, usually weekly. Patients were carefully observed for the presence of neurological side effects. All patients were maintained on a diet low in biogenic amine precursors throughout the study.

To date, 13 patients have been studied. The first 6 patients received L-tryptophan only. One patient was then given a 4-day trial of L-dopa and L-tryptophan and another patient had a 4-day trial of low doses of L-dopa at the end of a 16-day L-tryptophan study. Five patients received the combination of L-dopa and L-tryptophan for 8 to 19 days after trials of L-tryptophan alone.

Medication was given in three divided doses. Daily doses of pyridoxine (150 mg) and ascorbic acid (900 mg) were also administered during the placebo and active drug periods.

RESULTS

Double-Blind Administration of L-Tryptophan Alone

Of the 6 patients who received only L-tryptophan, 4 failed to have an antidepressant response, 1 had an equivocal response in that she improved but failed to have a posttryptophan worsening of depression, and 1 patient had a good antidepressant response to L-tryptophan. The results of these 6 patients and of a 7th patient who also did not have a clinical antidepressant response during either L-tryptophan treatment or 4 days of treatment with L-dopa are presented in table 1. Of the L-tryptophan nonresponders, 4 patients subsequently had a clinical antidepressant response to a nonblind trial of a monoamine oxidase inhibitor. One bipolar-I patient improved significantly during treatment with L-tryptophan but continued to improve when L-tryptophan was discontinued. She was then treated with lithium and was discharged from the hospital. In evaluating her drug response, we consider her improvement most likely to be related to a spontaneous remission. No drug side effects occurred during the L-tryptophan trials.

Double-Blind Administration of L-Tryptophan with L-Dopa

Five patients had prolonged trials of the combination of L-tryptophan and L-dopa, and their clinical results are presented in table 2. None of these patients had an antidepressant response during treatment with L-tryptophan alone. One patient had an antidepressant response as L-dopa was gradually increased to a daily dose of 6 g, but she failed to have a depressive rebound with placebo resubstitution. She was subsequently treated successfully with protriptyline. A second patient improved slightly during treatment with L-dopa and showed a relapse of depressive symptoms when placebo was substituted. He was then successfully treated with protriptyline and lithium. Although this patient had a history of hospitalization for mania, he did not develop a manic-like state during his 14 days of combined treatment with L-dopa and L-tryptophan.

The other 3 patients failed to improve after L-dopa was added. One patient had a psychotic depression that became much worse during the period of combined treatment, and she attempted suicide. Subsequently she was successfully treated with electroconvulsive treatments.

Symptomatic postural hypotension at 5 g of L-dopa was noted in 1 patient. Otherwise, no side effects, neurological signs, or laboratory abnormalities were noted.

TABLE 1
Response to L-Tryptophan Alone

Patient			L-Tryptophan Administration			Poststudy Treatment	
Age	Sex	Diagnosis	Daily Dose (g)	Number of Days	Response	Drug	Antidepressant Response
30	F	Unipolar	9	17	None	Phenelzine	Good
38	F	Unipolar	9	10	None	Phenelzine	Good
31	F	Unipolar	9	12	Good	Tranylcypromine	None
45	M	Unipolar	9	11	None	Phenelzine	Fair
29	F	Unipolar	9	12	None	Imipramine	None
						Tranylcypromine	Good
54	F	Bipolar-1	9	14	Equivocal	None—spontaneous recovery	
61	F	Unipolar	9	16*	None	Tricyclics	None
						MAO inhibitors	None

*Includes 4 days of combined therapy of L-dopa of 3 g per day.

TABLE 2
Response to L-Dopa in Combination with L-Tryptophan

Patient			L-Tryptophan Alone			L-Tryptophan with L-Dopa			Poststudy Treatment	
Age	Sex	Diagnosis	Daily Dose (g)	Number of Days	Antidepressant Response	Total Days of Combined Therapy	Number of Days of L-Dopa Therapy (more than 4.5 g)	Antidepressant Response	Drug	Antidepressant Response
33	F	Unipolar	9	18	None	8	6	Equivocal	Protriptyline	Good
28	F	Unipolar	9	17	None	18	7	None	Phenelzine and lithium	Worse
									Imipramine	Good
41	F	Unipolar	8.4	14	None	19	13	Worse, suicide attempt	Phenelzine	Fair
									ECT	Good
48	M	Bipolar-1	9	18	None	14	7	Fair	Protriptyline and lithium	Good
53	M	Bipolar-2	9	14	None	14	6	None	Lithium	Fair

DISCUSSION

The theoretical basis of this study was that a possible reason for the lack of antidepressant response to L-dopa in certain depressed patients (particularly unipolar patients) could be related to the concomitant decrease in central nervous system 5-HT turnover during L-dopa therapy. Since L-tryptophan enhances turnover of 5-HT in brain, during the combined use of these drugs both the turnover of 5-HT, DA, and possibly NE would be augmented. Bunney and associates (21) reported 7 patients who received separate trials of L-dopa and L-tryptophan. Whereas some antidepressant effect was noted with each drug, treatment with imipramine resulted in a more pronounced improvement.

Although this is a preliminary report, the data obtained thus far in 3 unipolar patients fail to support the notion that an antidepressant response to L-dopa can be obtained by pretreating patients with L-tryptophan. The equivocal response seen in 1 unipolar patient was not as striking as her subsequent response to protriptyline. A second unipolar patient appeared to become worse during L-dopa treatment, and the third unipolar patient who had no response to combined treatment had a good antidepressant response to imipramine during an earlier hospitalization.

A general lack of antidepressant response to L-tryptophan alone was observed in most of these patients. Although some of these trials were of short duration, Coppen and associates (9) demonstrated an antidepressant response to L-tryptophan within 10 days of treatment by administering L-tryptophan alone to 8 patients with a mean age of about 55 who were described as unipolar depressives. It is unclear if any of their patients had histories of hypomania. Furthermore, their patients responded as well to L-tryptophan as to imipramine. The patients reported in our study were younger, which may be a source of the difference in the clinical results of the two studies. However, antidepressant effects of L-tryptophan could not be demonstrated by Carroll and associates (10) or by Murphy and associates (11), although a more recent study by Murphy and associates (22) noted that L-

tryptophan has some antidepressant effect in bipolar-I patients but not in unipolar patients.

Van Praag and Korf (23) reported that 3 of 5 depressed patients had an antidepressant response with 5-hydroxytryptophan (5-HTP), a more immediate 5-HT precursor than L-tryptophan. However, only 1 of 7 depressed patients studied by Brodie and associates (24) had a therapeutic response to 5-HTP.

The use of the precursor-load strategy to effect higher concentrations of biogenic amines in the central nervous system is predicated on the ability of amino acid precursors to cross the blood-brain barrier and be converted to functional biogenic amines. In the interpretation of the preliminary clinical results from our study, pyridoxine, a cofactor in the decarboxylation of 5-HTP to 5-HT (25), interferes with L-dopa metabolism, apparently through the formation of a chemical complex between L-dopa and pyridoxal 5-phosphate (26, 27). Thus further studies of combined treatment with L-dopa and L-tryptophan will need to consider the possible interference of pyridoxine with the desired biological effect.

CONCLUSIONS

The catecholamine hypothesis of affective disorders has provided a useful theoretical framework for the investigation of biological factors in depression. If central nervous system catecholamine metabolism is reduced in some depressions, certain depressions should be alleviated by the administration of biogenic amine precursors. Similarly, the administration of drugs that decrease catecholamine metabolism should result in improvement of manic states. Negative results from the administration of biogenic amine precursors to depressed patients and equivocal or negative results in mania using α-methyltyrosine, an inhibitor of catecholamine synthesis (17, 27), or fusaric acid, an inhibitor of dopamine-β-hydroxylase (28), have led several investigators to question the role of the catecholamine hypothesis as a basis for continued research in affective illness (29, 30).

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Elevated Blood Serotonin Concentrations in Unmedicated Chronic Schizophrenic Patients: A Preliminary Study

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The authors found higher serotonin concentrations in the blood of unmedicated chronic schizophrenic patients than in the blood of medicated schizophrenic patients or normal control subjects. This finding is consistent with the previous observation that the level of monoamine oxidase activity is low in the platelets of chronic schizophrenics.

THERE ARE SEVERAL lines of research investigating the postulated changes of serotonin in schizophrenia (1, 2). One of the approaches has been the direct measurement of the amine or its metabolites in the body fluids of patients (1, 3–6).

Extending this approach to the study of enzymes participating in the metabolism of serotonin and other monoamines, we recently found that platelet monoamine oxidase (MAO) activity is significantly reduced in chronic schizophrenic patients and that this reduction is probably genetically determined (7, 8). Since serotonin is a substrate for platelet MAO where it is taken up from the plasma and stored (9), we speculated that platelet serotonin concentration would be elevated in schizophrenic patients compared to control subjects. We are reporting herein the results of a preliminary investigation on the levels of serotonin in the whole blood of schizophrenic patients. Since most blood serotonin is found in platelets, platelet counts were made on each sample to exclude the possibility that variations in blood serotonin were due to an alteration in platelet concentrations.

METHOD

Sixteen hospitalized chronic schizophrenic patients were studied (10 men and 6 women; mean age=27 years, range of 17 to 35 years). Diagnoses reflected a consensus of three psychiatrists. The control group consisted of 20 healthy volunteers (13 men and 7 women; mean age=29 years, range of 20 to 35 years) not receiving any medication. Venous blood was drawn between 8:30 and 10:00 a.m. into ACD solution (acid-citrate-dextrose, formula A, Becton-Dickinson Co.). Samples were immediately placed in ice and analyzed within four hours.

Platelet counts were made in a Coulter Counter, model B (Coulter Electronics, Inc.). Serotonin was extracted from 2 ml of blood (10); however, measurements of serotonin in blood extracts using 5-hydroxyindole native fluorescence were not satisfactory because of the low amount of fluorescence. Consequently, we used a modification of the *o*-phthalaldehyde (OPT) method (11) with the addition of cysteine (12). Separate blanks (OPT omitted) and internal standards were used for each sample. Individuals who performed the serotonin and platelet measurements were blind as to experimental designations of patients versus control subjects.

Repeated determinations were made over a period of at least two weeks to two months in 8 subjects as a means of investigating the stability of serotonin concentrations and platelet numbers over time.

Means were used when several measurements were made on the same control subject. All patients were first considered as one group and then divided into two groups according to whether or not they received drug treatment. When the patients were considered as a single group, grand mean measurements were used. In three of the patients, measurements were made in both drug-free and drug periods and the respective means are included in both groups. A two-tailed t test was used to evaluate any significant differences between groups.

Drug-free patients were off medication for three to five weeks before the collection of blood. Patients under drug treatment received various combinations of phenothiazines, amitriptyline, and, in most cases, small doses of trihexyphenidyl (Artane) or benztropine (Cogentin).

In an attempt to investigate acute effects of diet, we compared serotonin levels and platelet counts in three volunteers in a fasting state and one hour after breakfast.

RESULTS

In the three subjects in whom the acute effect of diet was studied, serotonin and platelet values did not differ significantly between the fasting samples and the samples taken after breakfast. These results confirm the experience of others (10, 13). Therefore, samples were taken

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TABLE 1
Serotonin Concentrations in the Blood of Chronic Schizophrenic Patients and Normal Control Subjects

Subjects	Age (years) Mean	SEM	Platelets ($\times 10^3$/ml blood) Mean	SEM	Serotonin (ng/ml blood) Mean	SEM	Serotonin (ng/10^8 platelets) Mean	SEM
Control (N=20)	29.6	1.1	241	11	186	12	80	4
Patients								
Total group (N=16)	27	1.4	231	12	232	21*	103	9**
Medicated (N=12)	28.3	2.2	230	13	199	17	90	9
Drug free (N=7)	26	1.6	245	25	298	28***	127	12†

*Significantly different from control subjects ($p<.05$).
**Significantly different from control subjects ($p<.025$).
***Significantly different from control subjects and medicated patients ($p<.01$).
†Significantly different from control subjects ($p<.01$) and medicated patients ($p<.05$).

without regard to the fasting state. Serotonin and platelet content of blood were relatively stable in the same individual. In one subject five determinations were made over a period of two months, and mean serotonin and platelet values were 180 ng/ml (SEM=4) and 286 $\times$ 10^6/ml (SEM=5), respectively.

Whole blood serotonin was significantly higher in the patients considered as a single group than in the control subjects. As seen in table 1, mean whole blood serotonin was 186 ng/ml for control patients and 232 ng/ml for schizophrenic patients ($p<.05$). This difference remained significant when corrections for platelet counts were made. When the patients were divided into medicated and unmedicated groups, however, this difference was almost exclusively due to the very high levels of serotonin in the drug-free group. Also, mean whole blood serotonin was 298 ng/ml for the drug-free patients, compared with 199 ng/ml for the patients receiving psychotropic medications ($p<.01$). The patients on drugs did not differ from the control subjects. These differences are not explainable on the basis of age or platelet counts.

DISCUSSION

Our finding of high serotonin concentrations in the blood of drug-free schizophrenic patients is consistent with the previous observation that MAO activity is low in the platelets of such patients (7, 8). In order to determine whether these two conclusions are interrelated in a cause and effect manner, we must consider several factors in addition to platelet MAO activity. Blood or platelet serotonin concentrations are influenced by the rate of synthesis of the amine, its entry into the blood, plasma MAO activity, and the functional status of uptake, storage, and release mechanisms in the platelets. It is not known whether these factors operate normally in schizophrenia. Furthermore, serotonin is only one of the amines metabolized by the platelet MAO and is not, in fact, a very good substrate for this enzyme (13).

Another point raised by our results is the importance of the effect of medication. Serotonin levels were much lower (approaching control levels) in the medicated patients than in the drug-free group (table 1). The effect of drugs is not unexpected, since both phenothiazines (14) and tricyclic antidepressants (15–17) are potent inhibitors of the uptake mechanism of the monoamines in platelets and probably in the brain as well (17). Apparently, the effect of drugs counteracts any increase in serotonin due to reduced platelet MAO activity. Phenothiazines, however, do not appear to affect the activity of platelet MAO (3, 18). The effects of trihexyphenidyl and benztropine on whole blood serotonin are unknown because not enough patients were studied to control for these drugs.

The relationship between blood and brain levels of serotonin is unknown. Although the platelet has been proposed as a model for monoaminergic nerve endings (19), regulation of serotonin levels and turnover in the brain depends on the interplay of many complex factors and therefore may not parallel blood levels of the amine.

Two studies of blood serotonin levels in chronic schizophrenics reported low levels (3, 5), while two other studies found that serotonin was lower in chronic patients than in acute psychotics (4, 6). These latter two studies, nevertheless, disagreed because one (4) found that chronic patients had normal values, while the other (6) found that chronic patients had elevated values. However, these reports cannot be compared to the present study because they did not mention possible drug effects, age, matching, and platelet counts. On the other hand, our results are similar to the high serotonin levels found in the blood of children suffering from early infantile autism (13), a disease that is considered by some to belong to the schizophrenic nosological group.

Further studies will be required to determine whether blood levels of serotonin are influenced by nonspecific factors such as chronic hospitalization, diet, and psychological stress, or whether psychiatric patients with other diagnoses exhibit normal levels of blood serotonin.

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Psychopharmacologic Management of Patients: A Method for Recording Treatment Decisions

BY DAVID J. KUPFER, M.D., AND THOMAS P. DETRE, M.D.

The authors describe a drug treatment form they designed, the KDS-8, that is suitable for use in all types of treatment settings. An important feature is a checklist of treatable target symptoms, with categories of improvement, no change, or worsening. Changes in drug regimen and the clinician's reasons for them are noted. Among the advantages the authors cite are easy retrievability of drug treatment data and the form's suitability for use in audit procedures and research.

THE MOVEMENT toward a new type of medical record that is easily accessible to various audit procedures and at least partially retrievable by automated methods has been considerably accelerated since the introduction of the problem-oriented system (1). However, the pace of these developments has been slower in psychiatry than in other medical specialties. Most psychiatric record keeping systems are still in an experimental stage (2–4), and those which have gained reasonably wide acceptance were designed primarily for hospitalized patients.

As we tried to retrieve data for retrospective studies of treatment efficacy, we became convinced that the current method of record keeping in psychiatric outpatient departments is simply a haphazard collection of statements entered in chronological order. Such records are supposed to be informative about the patient's condition, the treatment prescribed, and the evaluation of its effectiveness, but they do not fulfill any of these promises. On the contrary, despite the fact that an increasing number of patients receive drug maintenance therapy along with other supportive aftercare services, it is often impossible

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to determine why a particular therapeutic regimen was prescribed and what the clinician's reasons were for the frequent and often multiple changes that took place in the course of a patient's management. Having analyzed the clinician's tasks in making treatment decisions involving the use of drugs, we constructed a drug treatment form, the KDS-8. modeled along the lines of a problem-oriented record system. A reprint of the form is shown in appendix 1.

METHOD

One of our goals in designing the KDS-8 was to create a relatively independent chart component that would aid the clinician and others who might have contact with the patient or the record by providing a comprehensive overview of the following factors: 1) the patient's target symptoms, 2) the dosage of the drug(s) prescribed, 3) changes in treatment regimen, 4) the reasons for change, 5) side effects observed in the course of treatment, and 6) indications for and results of laboratory and diagnostic studies.

Clearly, whether the clinician is evaluating a patient who is a candidate for drug therapy or one who is already receiving psychotropic medication, his first task is to identify treatable target symptoms, since such symptoms are the reason for the initiation of drug treatment and serve as a test of the efficacy of the drug(s) prescribed. If the patient has been receiving psychotropic medication, the evaluation consists of determining whether the target symptoms have improved, remained unchanged, or worsened; it also notes whether there are any side effects and, if so, whether they indicate allergic or idiosyncratic reactions or are significant enough to require additional laboratory and diagnostic studies (which are likely to be ordered when the clinician judges the adverse effects to be out of proportion to the dosages administered). Studies may also be required when the prescribed drug tends to produce certain toxic effects that can best be monitored by biochemical or neurophysiologic tests as opposed to clinical observational methods, or when the drug in question must reach certain blood levels for optimal therapeutic effect (as may be the case with lithium).

The KDS-8 also gives the clinician an opportunity to spell out the reasons for his treatment decisions. Thus, whether he decides to continue the same drug and dosage, to increase, decrease, or stop the drug, or to prescribe an entirely new one, the relationship between treatment response and treatment decision can be clearly delineated. For instance, when the clinician believes that the patient's target symptoms have improved, he may (depending upon the course of the patient's illness and other clinical data) decide to leave the treatment regimen unchanged until he can determine whether the remission is stable. Alternatively, he may decide to decrease or even discontinue the drug(s) altogether. If the target symptoms have improved insufficiently or not at all, he might increase, decrease, or stop the drug, or try a new agent. Severe side effects may also lead to major changes in management, since the clinician may decide to prescribe a drug to control them (e.g., prescribing antiparkinsonian agents for extrapyramidal side effects), or he may decrease or stop the drug or prescribe another agent that is less likely to produce the same undesirable effects. A drug may also be discontinued when other drugs are being introduced in the patient's overall treatment regimen that are not compatible with it. Finally, a change in regimen may be required because of the patient's unreliability or the unavailability of other people to assume responsibility for administering the drug.

Space is also provided on the KDS-8 for entering all changes in the patient's condition or environment that may have a bearing on the overall management of the case (e.g., intercurrent nonpsychiatric conditions, suicide attempts, assaultive behavior, and changes in the patient's work functioning, relationship to family members, or other supports in the social environment).

DISCUSSION

The KDS-8 drug treatment form has been in use for two years in a variety of inpatient and outpatient settings and has proven to be superior to the highly individualized and imprecisely written entries usually recorded in the course of treatment. The clinician can at a glance obtain information regarding the drug treatment a patient is receiving, determine what the target symptoms are, and learn how the patient has been responding to a drug. In addition to improving the quality of care by making data easily retrievable, this form is also suitable for various audit functions, for large-scale studies of treatment efficacy, and for the surveillance of adverse effects.

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APPENDIX 1
KDS-8 Drug Treatment Form

KDS™-8
DRUG TREATMENT FORM

IMPRINT PLATE (NAME OF PATIENT AND FACILITY)

Date _____

(All items refer to treatment decisions made at the completion of this evaluation)

Type of Prescription: DPA [ ] County [ ] "Self-pay" [ ]

CURRENT TREATMENT SETTING: Outpatient [ ] Day Hosp. [ ] Night Hosp. [ ] Halfway House [ ] Other (specify) _____

Clinically apparent side effects: CNS [ ] CV [ ] GI [ ] HEM [ ] SKIN [ ] SPECIFY SIDE EFFECTS _____

LABORATORY AND DIAGNOSTIC STUDIES

	Ordered	Received		Ordered	Received
CBC	[ ]	[ ]	T_3, T_4	[ ]	[ ]
HCT	[ ]	[ ]	BUN	[ ]	[ ]
WBC, DIFF	[ ]	[ ]	ELECTROLYTES	[ ]	[ ]
BILIRUBIN	[ ]	[ ]	EKG	[ ]	[ ]
SGOT	[ ]	[ ]	EEG	[ ]	[ ]
ALK PHOS	[ ]	[ ]			
SER LITHIUM	[ ]	[ ]	_____ mEq/L		

TREATABLE TARGET SYMPTOMS	TREATMENT RESPONSE SINCE LAST VISIT		
	IMPROVED	UNCHANGED	WORSE
*[ ] Anxiety	[ ]	[ ]	[ ]
[ ] Neurotic symptoms, other than anxiety	[ ]	[ ]	[ ]
[ ] Impulsivity	[ ]	[ ]	[ ]
[ ] Intellectual Dysfunctioning	[ ]	[ ]	[ ]
[ ] Hypomania and mania	[ ]	[ ]	[ ]
[ ] Depression	[ ]	[ ]	[ ]
[ ] Psychotic symptoms	[ ]	[ ]	[ ]
[ ] Decreased sleep	[ ]	[ ]	[ ]
[ ] Increased sleep	[ ]	[ ]	[ ]
[ ] Other_____	[ ]	[ ]	[ ]

[ ] No current target symptoms

*Check all target symptoms present prior to the administration of psychotropic drug(s).

NAME OF DRUG	Single Dose in Mg.	Dosage Schedule	Change in Schedule	Indicate Route By No. (See legend below)	CHANGE IN DRUG REGIMEN: NONE	INCR	DECR	STOP	NEW	REASONS FOR CHANGE: Remission of Target Symptom	Adverse Effects	Incompatible with Current Med. Mgmt.	Ineffective	Patient Not Reliable
1. _____	_____	_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
2. _____	_____	_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
3. _____	_____	_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
4. _____	_____	_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
5. _____	_____	_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

1-tablet; 2-capsule; 3-oral liquid (concentrate); 4-sustained release (spansule); 5-IM; 6-IV; 7-subcutaneous; 8-suppository

NOTES: (Include proposed treatment plan)

Signature of Clinician: _____

Signature of Senior Clinician (if any) _____

KDS-8 (TM)
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Civil Liberties Versus Involuntary Hospitalization

BY STEPHEN RACHLIN, M.D., ALVIN PAM, PH.D., AND JANET MILTON, M.S.W.

The authors examine the issue of involuntary hospitalization for mental illness with particular reference to legal rights and civil liberties. Follow-up data of patients treated on a closed ward, as well as other available evidence, indicate that society is not ready for the abolition of involuntary hospitalization. The authors believe that the most fundamental right of the patient is that of adequate treatment, and therefore this should take precedence over an absolute right to liberty.

"WE SHOULD VALUE LIBERTY more highly than mental health, no matter how defined" (1). With this statement, made over a decade ago, Szasz issued a call for the abolition of all provisions for involuntary mental hospitalization. He went on to state that "no one should be deprived of his freedom for the sake of his mental health" (1). Thus began a campaign, in the name of civil liberties, to eliminate involuntary hospitalization. An organization of ex-patients, the Mental Patients Liberation Project, has dedicated itself to this end.

Bruce Ennis, the attorney who directed the Civil Liberties and Mental Illness Project of the New York Civil Liberties Union, has recently added momentum to the movement. He also has as his goal "nothing less than the abolition of involuntary hospitalization" (2). He believes that the standards for two-physician certification for commitment are ambiguous and questions their legitimacy. Feeling that "it makes no sense to put people in mental hospitals," he advised that they be shut down and all treatment be provided in the community.

Fischer and Weinstein (3) stated, "Psychiatry has no rival among medical specialties in its susceptibility to fads and its readiness to board the newest bandwagon." They cautioned us to avoid rushing in before strengths and deficiencies are appraised and not to allow our enthusiasm to impair our judgment, with the attendant consequence of losing the benefits of established ways.

It is our purpose in this article to examine the question of involuntary mental hospitalization from the standpoint of the profession, the patient, and the community, with particular reference to legal rights and civil liberties.

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

At the time this work was done, the authors were with the Williamsbridge-Fordham Unit, Bronx Psychiatric Center, Bronx, N.Y., where Dr. Rachlin was Chief of Service, Dr. Pam is Supervising Psychologist, and Ms. Milton is Psychiatric Social Worker. Dr. Rachlin is currently Deputy Director, Meyer-Manhattan Psychiatric Center, Ward's Island, N.Y. 10035. Drs. Rachlin and Pam are also Assistant Clinical Professors of Psychiatry, Albert Einstein College of Medicine, Bronx, N.Y., and Ms. Milton is Field Instructor, Hunter College School of Social Work, New York, N.Y.

PRESENT STATUS OF INVOLUNTARY HOSPITALIZATION AND PATIENTS' RIGHTS

The following statement describes, in part, the official position of the American Psychiatric Association on the issue of involuntary hospitalization of the mentally ill:

> Unfortunately, a small percentage of patients who need hospitalization are unable, because of their mental illness, to make a free and informed decision to hospitalize themselves. Their need for and right to treatment in a hospital cannot be ignored. In addition, public policy demands that some form of involuntary hospitalization be available for those mentally ill patients who constitute a danger either to themselves or to others. (4)

In an overview article, McGarry and Kaplan (5) reviewed the various state statutes related to admission. They noted the increasing use of voluntary admissions and the significant limitations on the wholesale use of the involuntary admission provisions as the standards for the latter become more stringent. Another important trend is the establishment, by law, of the right of the patient to legal representation.

Our own state of New York has a new mental hygiene law, which defines "in need of involuntary care and treatment" as the situation in which "a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment" [NY Mental Hyg Law, Article 31, s 31.01]. The patient's right to a judicial hearing following involuntary admission on medical certification is assured, as is his notification relative to such a right. The maximum period for this type of hospitalization is 60 days.

The rationale in support of involuntary hospitalization has been described by Robitscher (6), who, citing Birnbaum, noted the right of the involuntarily hospitalized patient to receive adequate treatment in exchange for his being deprived of his liberty. The benefits of treatment enable the patient to regain his liberty at an early date and thus legitimize his hospitalization. Without this, the due process standard is not met, and the patient should be released. The right to treatment has been affirmed as a constitutional right, and it is the only justification for civil commitment.

EXPERIENCES WITH A CLOSED WARD

We worked as part of the treatment team on what was, at the time, the only locked ward at Bronx Psychiatric Center (formerly Bronx State Hospital). This intensive care unit (ICU) treated patients who had a special need for the added structure and setting of firm limits. Our patients were accepted on referral from the open wards if they were treatment failures because of repeated elopement, dangerousness to themselves or to others, or severely disturbed and agitated behavior. The utilization, problems, and advantages of the ward's program have been discussed in a previous paper (7). Because the ward door was always locked, the setting would presumably be considered offensive by most civil libertarians.

To answer the question of what happened to patients so treated, we undertook the present follow-up study. Each of the first 50 consecutively admitted patients (34 men and 16 women) completing a course of treatment in the ICU was used as his/her own control. A comparison was made between the one-year period prior to the index admission and the one year subsequent to first release from the ICU. Using the criteria of number of hospitalizations, interval between admissions, and total time spent as an inpatient, we were unable to demonstrate any statistically significant differences between the pretreatment and posttreatment years for the group as a whole. Similarly, we could not prove any marked reduction in the overall incidence of those behaviors that led to the original referral.

In studying the data, we were struck by the wide individual variability among the subjects. Therefore we rated each patient on a global basis, and we achieved nearly perfect agreement by consensus after reviewing all available records. Fourteen patients (28 percent) were considered to be improved. Of these, 5 were much improved in that they spent the entire follow-up year in the community and out of the hospital. The other 9 were hospitalized for portions of the year, but showed little repetition of the behaviors that led to their transfer to a closed ward. Almost half of our patients (N=23) showed little change in symptoms throughout most of the follow-up period. We rated 6 patients (12 percent) as worse. No useful ratings could be made for 7 patients (14 percent) because data were not obtainable, the usual reason being the patient's departure from New York.

Interpretation of the global follow-up ratings is difficult. It is, however, our feeling that the results are generally positive, since one must bear in mind that we were dealing with the most difficult-to-treat group of patients that could be selected. These individuals simply did not "make it" in the more usual treatment setting. For a fair number of them, their stay on the ICU interrupted or reversed a course of patienthood that had previously spiraled continually downward.

To directly relate our experiences to the main theme of this report, let us look into the reactions to closed ward treatment. It may be stated unequivocally that the community was strongly in favor of such a treatment modality and, at times, distressingly so. Not once in the two years of our study was there a complaint from any relative, group, or other interested party that we were locking up someone needlessly. Rather, the reverse was true. The pressure was clearly in the direction of treating more patients in the closed ward setting, and there were frequent requests from various individuals outside the hospital that patients be admitted to our ward.

We were confronted with the painful fact that the community does not understand, sympathize with, or want these individuals in its midst. Witness the following: In one case, persons representing themselves as spokesmen for an ethnically oriented social and political action group accompanied a patient to the admitting room of the hospital to assure her admission to a locked ward; they contended that she had thrown her newborn infant into a trash can on the street. Because of the nature of her behavior, and the social pressure, the patient was accepted for direct admission to the ICU. We later learned that the story was pure fabrication. The community had defined the patient as a nuisance, and it wanted to make sure that she stayed in the hospital.

In another instance, a young male patient arrived with several notes scrawled on the admitting papers sent from the community general hospital indicating that he was "to be admitted to a closed ward by order of Commissioner X [a name was given], New York City Department of Health." While we were under no obligation to heed these instructions, we did so. Within a day it was learned that no such commissioner existed. These examples illustrate the fact that community groups will go to great lengths, including subterfuge and misrepresentation, to rid themselves of the "troublesome" mentally ill.

As indicated in a previous report (7), our patients rarely objected to the locked ward, and when they did so, it proved to be an objection to being in the hospital rather than on a particular ward. A large number of the patients signed agreements to remain as voluntary patients with full knowledge of the fact that they would be kept on the ICU as long as the staff felt that it was necessary. In their discussion of the advantages of a closed ward, Fischer and Weinstein (3) stated, "In the readmission of former patients, there has not been one instance in 10 years in which the locked door was objected to by either the patient or his relatives." Our experience was essentially the same.

THE POSITION OF THE COMMUNITY

One of us (S.R.) served as chief of an open-door service at Bronx Psychiatric Center. In that capacity, monitoring the interface between hospital and community was one of his principal functions. The direction that families take is eminently clear. Whether they bring their requests to the ward staff, the chief of service, the director, or even the commissioner, it is their desire that the patients be kept in the hospital when we feel that they are ready for discharge to the community. Answering such complaints has become part of the daily routine of the

hospital staff. In cases where the family wanted to have its relative removed from Bronx Psychiatric Center, it was because of their objection to the open doors.

By no means are these family attitudes always, or even often, desirable. We mention this simply to point out that families cannot be overlooked in a cavalier fashion. They tell us something about societal misapprehension, capacity to tolerate deviance, and the tensions and problems of living with psychotics. If we plan to release a patient to his family, it behooves us to see to it that the environment to which he will return is not a rejecting one. We must recognize that the family also has certain rights and that these are not always compatible with having a seriously disturbed and untreated patient residing in the household.

In surveying community attitudes toward mental illness, Bentz and Edgerton (8) reported an important difference between the general public and the defined community leaders. Significantly fewer of the latter group believed that mental hospitals are needed to protect the community from the mentally ill (35 percent versus 70 percent of the general public). The public saw the protective aspect as a primary role of the hospital. These findings serve to remind us that what the most vocal members of society may be saying is not necessarily indicative of the grass-roots sentiment.

A look at what happened in California in 1973 may be enlightening. That state had announced plans to phase out its state mental hospitals within the next few years. A legislative committee investigating the possible impact of this decision heard complaints that the state laws, while designed to protect patients' civil rights, were then too liberal with regard to the release of potentially dangerous patients (9). There were also accusations that the hospitals were "dumping" patients into communities unprepared to care for them. The strength of public opinion resulted in the reversal of the decision to abolish state hospitals (10).

Aviram and Segal (11) detailed some of the mechanisms that communities are developing to continue to exclude their mentally ill in the face of current trends toward community-based care. They presented evidence that the penal code is increasingly used to commit patients for long-term care. "Ghettoization" and bureaucratic maneuvering were among the other techniques they discussed. They provocatively titled the final section of their paper "From Back Wards to Back Alleys."

Making a plea for a continuum of treatment facilities, Mosher and Gunderson forewarned us,

> First, it must be recognized that most people would rather not be confronted on a day-to-day basis with behavior that is defined as socially deviant; and one result of the community orientation of mental health care will certainly be increased contact with deviance. Furthermore, the patient's deviant behavior is likely to adversely affect his family's functioning and may cause considerable embarrassment. If we demand that families assume primary responsibility for the care of an ill relative, without provision for *their* needs, we can expect a backlash against our community-oriented efforts, and the voice of the average man in the street, who has also been discomforted by the deviant behavior of patients, will be added to the families' chorus unless we provide for *his* needs. (12, p. 48)

DISCUSSION

Critics of psychiatry will always be with us. They serve the useful function of forcing us to examine where we are, how we got there, and where we are going.

In this case, we do not deny the good intentions of those civil libertarians who advocate the abolition of involuntary hospitalization. There is, however, a critical danger to which we must not succumb. A few individuals set themselves up in an elitist fashion, pretending to speak for the masses as to what is right. They make their statements without first finding out what the public wants. Lives are affected thereby.

We believe that the weight of the evidence reviewed, both ours and that of others, clearly indicates that society is not ready for the abolition of involuntary hospitalization. Certainly the wholesale use of such a procedure is not tenable. However, even though there are abuses, this does not mean that we must throw out the baby with the bath water.

The humane approach to serious impairment of mental functioning demands that the suffering of the patient be relieved. He must be helped to take his place in society comfortably. We believe that this right is more fundamental than, and therefore takes precedence over, that of liberty, for without appropriate therapy what do we offer the patient? It is true that he is free to come and go as he pleases, but what about the quality of his life? Can we really call it "liberty" if someone walks the streets in terror because of paranoid delusions or threatening hallucinations? Or if he is at home and subject to constant barrages from a rejecting environment?

Involuntary hospitalization remains the procedure of choice for a small group of patients who are seriously mentally ill and unable to make an informed decision as to their need for inpatient care. Such a hospital admission is not forever, but rather for a finite period of time. The rights of such patients require protection in the form of judicial review. *The overriding right is that of adequate treatment.* When it is provided, we can assure a more meaningful liberty for the patient, his family, and the community. We cannot surrender to the temptation to uphold an absolute right to liberty and, because of it, abrogate or negate many others.

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Brain Hypoxia, Minimal Brain Dysfunction, and Schizophrenia

BY H. ALLEN HANDFORD, M.D.

The author hypothesizes that individuals who suffer brain hypoxia prenatally, perinatally, or immediately postnatally constitute a population at risk for minimal brain dysfunction and for schizophrenia in adulthood. This hypothesis has implications for early intervention with children who have MBD and their families and for multidisciplinary management of these cases throughout childhood.

ON THE BASIS OF more than a decade of clinical experience with mentally ill children, including five years of research on early infantile autism (1), follow-up of these children extending into adulthood, and a review of the records of adult schizophrenics, I wish to propose a hypothesis developing from research focusing on brain anatomy and physiology. Simply stated, the hypothesis is that individuals who have survived prenatal, perinatal, or immediate postnatal hypoxia constitute a population at risk for the development of minimal brain dysfunction and, subsequently, of schizophrenia. A corollary of this hypothesis is that the type and age of onset of schizophrenia are determined within a system composed of the following factors: 1) the stage of brain development at which the hypoxia occurred, 2) the degree of hypoxia and related brain tissue damage, 3) the anatomic location within the brain (including brain stem) of the hypoxic effects, and 4) the patient's interaction with his family and social environment.

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The childhood disorder MBD, described by Strauss and Lehtinen (2) over 25 years ago, has gained increasing diagnostic, therapeutic, and educational significance in recent years. The manifestations of the disorder include impairment of social judgment, emotional lability, poor coordination, perceptual disability, and related learning problems. The functional disability of such patients ranges from mild to severe, and they require many modalities of therapeutic and educational intervention during childhood and adolescence. Moreover, as is shown in the following case report, these patients may be at risk in adolescence for the development of schizophrenia.

Case 1. Ms. A was a 21-year-old single woman who had been referred first at the age of 13 because she was "flapping about the school ground acting like superman." The clinical picture was one of borderline intelligence, impaired social judgment, and slow learning, with occasional poor reality testing. Her birth was premature, and oxygen was required during the first five days. Her development was slow but progressive during childhood, and she maintained an IQ of about 80. At age 17, she began having periods of decompensation, characterized by crying out in the night, extra sensitivity to voices, ideas of reference, and misinterpretation and fear of certain colors, graffiti, and designs. She expressed the delusion that she had aborted a fetus into the toilet at home. She had been diagnosed in early childhood as having nonpsychotic organic brain syndrome (MBD) secondary to prematurity. In adolescence, her symptoms strongly suggested a schizophrenic process.

The question of brain tissue damage in MBD has been a controversial one. Recent studies appear to have confirmed the existence of such damage, localized the brain areas affected, and isolated an important causal factor, brain tissue hypoxia, in both MBD and schizophrenia.

FETAL AND NEONATAL BRAIN SECTION STUDIES

In 1970, Towbin (3) reported clinical histories and autopsy material from over 600 live and stillborn infants. He preserved focal lesions by whole-brain histologic sectioning and consistently demonstrated their geographic relationship in the brain. He described four main types of central nervous system damage in the fetus and newborn: subdural hemorrhage, spinal cord and brain stem damage, hypoxic cerebral periventricular infarctional damage, and cerebral cortical infarctional damage. All of these but the first were implicated in the etiology of subsequent MBD or classic cerebral palsy.

According to Towbin, spinal cord and brain stem damage due to direct but often undetected birth trauma was responsible for most of the signs of neonatal distress determined in the delivery room or newborn nursery by the Apgar score. This is the case because the Apgar factors—initiation of respiration, sustained cardiac function, muscle tone, and irritability—depend on the intact functioning of the brain stem and upper cord structures. Traumata that contribute to such damage are breech delivery, forceps traction, prematurity (with the attendant difficult passage of a small infant through an unripe birth canal), first birth, and precipitous delivery. Respiratory depression from such direct damage produced sufficient hypoxia to cause cortical infarctional damage in term infants and to cause periventricular damage in premature infants.

Towbin reasoned that the differing sites of damage in term versus premature infants depended on the site of the neuronal germinal matrix, the area of the most rapidly developing neural tissue at any given time. He observed in his sections that this was where the blood supply was most diffuse, fragile, and prone to infarctional episodes secondary to hypoxia. The germinal matrix in the term infant from the 35th week of gestation through delivery and postnatally is in the cortical areas. Towbin noted that when damage occurred, it was histologically most evident in the Betz cells of the precentral cortex and the Purkinje cells of the cerebellum. Betz cells mediate motor function and Purkinje cells mediate coordination. Malfunction in these areas is consistent with two of the classical signs of MBD, impaired motor function and poor coordination. More severe classic cerebral palsy, with spasticity, ataxia, or athetosis indicating involvement of the basal ganglia (in the periventricular area), suggests hypoxic damage at an earlier stage of brain development.

In the Towbin series, premature infants of 28 weeks gestation were the most prone to develop the deep periventricular infarctional damage, since the greatest germinal matrix development at that time was in the periventricular area. Structures affected were the corpus striatum, basal ganglia, and thalamus. Conditions producing hypoxia prior to actual birth included partial placental separations (indicated by bleeding near the end of pregnancy) and shunting phenomena of the vascular supply system, seen in as many as 70 percent of monozygotic twins (4). These factors help to account for the various forms of brain damage that occur even when the actual delivery is uncomplicated and for the fact that the premature infant is at greater risk for such disability.

This evidence from fetal and neonatal studies strongly suggests the validity of the concept of structural as well as functional damage to brain tissue in MBD as well as in classic cerebral palsy. This theory awaits corroboration from histologic analysis of postmortem brain specimens, correlated with clinical histories of children of various ages.

BRAIN HYPOXIA AND SCHIZOPHRENIA

In 1973, Campion and Tucker (4) seriously challenged one key basis for the genetic hypothesis of the etiology of schizophrenia—i.e., the increased concordance for the disorder in monozygotic (MZ) twins as opposed to dizygotic (DZ) twins and singletons. In the process, they reviewed convincing evidence in support of the brain damage theory of the origin of schizophrenia. Citing anatomic, physiologic, and developmental data on MZ and DZ twins, they pointed out that, contrary to previous belief, the prenatal environments of MZ twins are not identical. Approximately 70 percent of MZ twins share a single chorion and are therefore subject to the intermittent reduction of blood supply to one fetus or the other, a phenomenon known as "transfusion syndrome." This may be so severe as to cause significant degrees of brain damage. Singletons, DZ twins, and 30 percent of MZ twins are not so affected because each has a separate chorion. It is worth noting that the concordance rate for schizophrenia in MZ twins is approximately 70 percent as opposed to the 100 percent rate that might be expected if MZ twins were environmentally and genetically equal. According to Towbin (3) this shunting is at fault in cortical infarction found in near-term twins. Campion and Tucker provided substantial evidence that MZ twins are at far greater risk than are DZ twins or singletons for disparities in intellectual development, congenital malformations, low birth weight, and infant mortality. They further maintained that perinatal complications and subtle neurologic damage are either part of the development of schizophrenia or essential elements of the disorder itself. Without the corroboration of the twin studies, the case for a genetic basis of schizophrenia is greatly weakened.

In an extremely complex analysis of anatomic and neurobiochemical data relating to parkinsonism and schizophrenia, Stevens (5) concluded that the characteristic symptoms of schizophrenic patients—preemption of consciousness by fear, a sense of unreality, and heightened or distorted sensory and sexual perceptions of an acute or chronic nature—are related to the excess production of, or increased sensitivity to, dopamine released locally from the dopaminergic pathways at the principal terminus of the dopaminergic system, the limbic striatal portion of the corpus striatum. Consistent with our previous conclusions, Stevens indicated that this could occur secondarily to damage and malfunction of the pathways from hypoxia, infection, or other injury. As further confirmation of aberrant brain function in schizophrenia, she

presented EEG data from nonepileptic schizophrenic patients recorded during periods of deranged mental activity or distraction by endogenous percepts (as evidenced by stereotyped behaviors and hallucinosis). These EEGs indicated abnormal potentials in the subcortical striatal areas. She concluded that there seemed to be a pathologic widening of consciousness in schizophrenic patients, characterized by an intensification of both endogenous and exogenous perceptions. This intensification generated the clinical state of disorganizing anxiety and irrational behavior. A key preliminary element in the treatment of schizophrenia would be pharmacologic agents such as the phenothiazines or butyrophenones, which directly affect dopamine metabolism at the pathway terminus and thereby narrow the field of consciousness to manageable proportions. This enables the patient to cooperate more effectively with nonpharmacologic life management programs.

CONCLUSIONS

The importance of recognizing a possible link between pre- and perinatal brain hypoxia, MBD, and schizophrenia through damage to the dopaminergic pathways cannot be overemphasized. The implications of this concept range from improvement of prenatal care and refinement of obstetrical techniques, through early intervention with developmental programs for infants at risk and their families, to multidisciplinary management of the child with MBD, including appropriate medication throughout childhood. The awareness that such children are handicapped and at risk for schizophrenia is of epidemiologic significance in delineating more clearly a target population for research and early case finding. Dynamically, so-called schizophrenogenic parents or families could be counseled in the more reality-based framework of understanding feelings toward such children and learning to cope with their affective and cognitive problems rather than focusing upon a dubious concept of parental causality, with its strong guilt-evoking overtones.

I am currently taking such an approach in collaboration with a multidisciplinary team consisting of a pediatrician, psychologist-educator, audiologist, pediatric neurologist, and special education teachers working with some 80 at-risk nursery school children and their families in a community-based child development center. Data gathering and analysis over a significant time span remains to be accomplished, but early indications of affective and cognitive development in the children and improved coping ability in their parents seem promising. In our program, attention is being paid to the subtle neurologic deficits with corrective medication, special developmental educational approaches, and parental counseling. This model of early intervention, based on the gradually developing concept of the neurophysiologic origin of schizophrenia, seems to offer new hope for the alleviation and even prevention of this enigmatic affliction.

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The Educational Process as a Treatment Modality in a Drug Rehabilitation Program

BY LEONARD SUCHOTLIFF, PH.D., AND SUSAN MEYER, M.A.T.

The authors describe an educational program that is an integral part of a residential drug rehabilitation program. They believe that effective treatment of drug addiction must provide individuals with the opportunity to acquire skills that will make it easier for them to compete in the job market when they leave the program. They discuss how the educational process serves as a treatment modality that supplements and complements the other aspects of the therapeutic community.

THE BASIC PREMISE of the Edon House long-term (14- to 18-month) residential drug rehabilitation program is that participation in a therapeutic community is not enough to help someone stop using drugs. Effective treatment must provide individuals with the opportunity to acquire skills that will make it easier for them to compete in the job market when they leave the program.

One of the major deficiencies noted in at least half of the addicts who have entered Edon House is that they have not completed high school. In order to meet this need, an educational program geared toward providing educational enrichment was initiated. Since its inception approximately two years ago, 65 residents have been prepared to take the General Equivalency Diploma (GED) examination; 55 residents have passed.

What makes the educational program at Edon House unique is that it is an integral part of the therapeutic community. The educational program is viewed as a treatment modality that supplements and complements other aspects of the program. In most therapeutic communities, educational achievement, if stressed at all, is seen as a peripheral activity that takes place outside the unit (e.g., adult education classes). Volunteer teachers whose services are isolated from other areas of the program are also sometimes used. In either case, educational achievement is encapsulated from the rest of the resident's life within the therapeutic community. It is usually seen as having little relevance beyond its functional utility ("You need an education to get a good job").

At Edon House, the resident's participation in the educational program is given equal weight with his participation in groups, job functions, and seminars. Education is seen as a particularly significant area not only because it is functionally useful to the resident but also because the very process by which the individual learns and the experiences he encounters in the school are therapeutic. The major aim of this paper will be to briefly describe the educational program at Edon House and to point out how the educational process and the therapeutic process complement and supplement each other.

At the time of the study the authors were both with Edon House, Fairfield Hills Hospital, Newtown, Conn. 06470, where Dr. Suchotliff is Director and Ms. Meyer was Educational Director.

THE EDUCATIONAL PROCESS AS THERAPY

The educational program at Edon House is designed to meet as many of the diverse needs of the resident population as possible. At present, the program features five key areas: the reading laboratory, GED classes, remedial- to college-level mathematics classes, precollege classes and various educational enrichment classes, and craft and vocational skill classes. Individual tutoring is also available.

The education department consists of a director whose area of specialization is English, a reading specialist who is in charge of the reading laboratory, and program residents who conduct mathematics classes and individual tutoring. Both the educational director and the reading specialist also conduct treatment groups and participate in daily case conferences. The job function of the tutoring residents within the house is that of schoolroom assistant. The educational director is responsible for the coordination of the school program with other aspects of the therapeutic community. The student residents, tutoring residents, and teaching staff are all members of the therapeutic community.

Residents attend classes on a voluntary basis. Once a commitment to a class has been made, however, the resident is held responsible to honor his obligation. A commitment is defined as extending from six weeks to two months, depending upon the course of study involved. At the end of this period, the resident decides whether or not he will renew his commitment and continue to attend classes. Since the Edon House school program represents a "last-ditch" chance at education for many residents, attendance is not a problem; the school is supported enthusiastically.

Every student enrolled in the educational program is evaluated individually in order to determine his particular level of reading speed and comprehension. A specific program of study is then mapped out to meet his needs.

This assessment forces the resident to confront his educational limitations directly. All the cunning and manipulative skill that were useful on the street are worthless here. The resident to whom educational achievement was not a relevant factor in determining his self-worth and status when he was using drugs must now readjust and evaluate himself and his position vis-à-vis others in terms of his ability to learn.

In the educational laboratory, where we use preprogrammed reading material and audiovisual machines, the student proceeds through the course at his own speed until he achieves his desired level of competency. Accurate responses are reinforced and errors are corrected immediately so that the student's primary experience is one of success.

In school more than in any other area of the program, goals and expectations are clearly defined; the resident gets continuous feedback on his progress and has a definite and objective barometer of success. In other areas of the program, he may fool himself and others by simulating concern, but in the educational program he cannot do this because progress is objectively definable. We have found that educational assessment and participation in the reading laboratory, which confront the resident with a clear picture of his own educational level, are the best image breakers available. They literally force the addict to acknowledge his deficiencies and to place himself in a situation where he is a learner who must depend upon others in order to get what he needs.

Changing the Hierarchical Structure

The structure of almost all therapeutic communities is hierarchical (1). Status in the program is generally based upon the resident's job in the house and how long he has been in treatment. A major advantage of the educational program is that it places individuals of differing status in the rehabilitation program in situations where their position in the hierarchy is not a relevant variable. Competency thus comes to be redefined in terms of educational achievement. An individual's progress in school becomes critical in determining his progress within the house. The resident's participation, his motivation, and his attitudes in school are communicated to the whole staff and are dealt with as any other behavior would be. In many cases treatment plans have been worked out whereby individuals have been assigned to certain courses or given positions of responsibility in the education department in order to work on areas of deficiency or to get positive reinforcement in areas of particular expertise.

In school we find such situations as residents who were considered more advanced depending on those thought to be less advanced, strong residents depending on meek residents, and men depending on women. In short, school undercuts the implicit assumption of therapeutic communities that the longer one is in treatment, the more competent he must be in all areas. In addition to imparting skills, the educational program clearly forces the resident to deal with social situations that he might not encounter in other areas of the program.

After a resident has successfully completed the reading laboratory, he may enroll in a class geared toward preparing him to obtain a GED. These classes are small; students are given instruction in grammar, literature, social studies, science, and mathematics. Intensive classwork is done for approximately two months. At the end of that period, those students considered sufficiently prepared may take the test for an equivalency diploma.

The Experience of Success

As the individual resident progresses in the educational program, he is not only achieving mastery over the material, which makes him feel more competent, but he is also mastering a skill valued by "straight" people. For many addicts the passing of the GED is their first concrete experience of success in the "straight" world. Residents who have successfully completed the GED express the view that their ability to complete school, something that previously turned them off, indicates that they may now be capable of dealing with other situations they had previously felt unprepared or unable to handle. It may be speculated that a correlation exists between success in school and the ability to complete the program and remain drug free.

For those residents who enter the program with high school diplomas, and for those who obtain them while at Edon House, precollege and various educational enrichment classes are offered. In addition, a Scholastic Aptitude Test course is given that prepares the resident to take that examination.

A relaxed and informal atmosphere prevails in these classes as well as in the reading laboratory. Residents are encouraged to be highly verbal, to do their thinking aloud, and to feel sufficiently at ease to make mistakes without the fear of being thought stupid. We foster the attitude that making mistakes is a natural and necessary part of the learning process, not a sign of weakness or a cause for embarrassment. Smooth talking for the purpose of manipulating others, however, is discouraged because this represents an attempt to hide one's ignorance. Only when a resident feels free to reveal what he does and does not know can true learning be initiated.

We would note the similarity between the educational philosophy and the underlying philosophy of the therapeutic community: both encourage the individual to redefine his concept of strength from one of being able to handle all situations adequately and without assistance to allowing himself to make mistakes and learn how to ask others for help. The ultimate goal of education and of therapy is to teach a method of problem solving that the individual can employ in new situations.

DISCUSSION

This educational program is predicated upon the philosophy and spirit that underlie all phases of the therapeutic community: commitment to change and the acceptance of responsibility. The value of a school program lies as much in its usefulness as a therapeutic tool as in its functional utility. It encourages the addict to confront his

strengths and limitations realistically and provides opportunities for him to experience success and develop feelings of self-esteem. The process of learning, whether it focuses on mastering unfamiliar subject matter, acquiring new skills, or understanding one's own behavior and redefining oneself in relation to others, is therapeutic; the therapeutic process is educational. The functional results of education, the techniques used in the school program, and the very nature of the learning process itself allow a treatment modality and dimension of rehabilitation unavailable to therapeutic communities that do not have such a program.

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Translating Despair

BY JAMES E. SABIN, M.D.

The author reviews two cases of suicide by Spanish-speaking patients who were evaluated and treated by English-speaking psychiatrists using a translator. He suggests that the patient's emotional suffering may be selectively underestimated when the clinician works by means of translation. The diagnosis may emphasize psychotic features of the illness and minimize the affective component; consequently the risk of suicide may be underestimated.

WITH THE DEVELOPMENT of community mental health centers and comprehensive neighborhood health centers, many of which serve Spanish-speaking populations, it is increasingly common for English-speaking mental health professionals, using translators, to evaluate and treat Spanish-speaking patients. Communicating in a common language would obviously be preferable, but the size of the Spanish-speaking population and the current dearth of Spanish-speaking mental health professionals make the use of translators a necessity.

The various techniques of clinical psychiatric evaluation have been developed in settings in which patients and clinicians, however different from each other, speak the same language. Speaking metaphorically, we say that the middle-class white clinician and lower-class third-world patient "don't speak the same language," but while the metaphor points to something real, it is a different form of noncommunication than occurs between the same professional and a Spanish-speaking patient. In medical terms, communication is a major instrument of clinical examination, and if the patient is using a second language or speaking through a translator, the instrument is altered and may produce altered results. For this reason, whatever method of evaluation an English-speaking practitioner may use, he cannot rely on it with the same assurance when he is working with patients who speak a different language. Similarly, the physician must adapt his ear to a new stethoscope before he can be confident in auscultation of the heart.

There is as yet no agreement as to how different languages in patient and clinician affect clinical evaluation, but there is clearly a pronounced effect. In a recent report Del Castillo (1) suggested that the bilingual patient may show less psychotic symptomatology when examined in English than when examined in his native tongue. He speculated that the mental effort required to speak in a second language puts the patient in better contact with reality and masks the psychosis that is apparent when the patient is interviewed in his language of origin. Marcos and associates (2), in an experimental study, reached the opposite conclusion, that "Spanish-American patients are consistently rated as showing more pathology when they are interviewed in English" (p. 552). The authors hypothesized that problems posed by speaking a second language produce changes suggestive of more pathology in the patient's clinical presentation and that a frame of reference applicable to native English speakers may not be valid when applied to an English interview with a native Spanish-speaking patient.

While differing in important details, these studies conclude that the bilingual patient appears different when examined in English than when examined in his native tongue. The differences noted are predominantly differ-

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ences in degree of psychosis (patients appearing more or less ill when examined under varying linguistic conditions). In principle it seems likely that altering the linguistic instrument may bring about apparent differences in kind of illness as well as apparent differences in degree of illness. I believe that the following cases illustrate the effects that translation can have on clinical evaluation.

CASE REPORTS

I have recently had occasion to review two cases in which Spanish-speaking patients evaluated by English-speaking psychiatrists in collaboration with a translator committed suicide. While both cases appear to reflect careful, responsible work, it is clear in retrospect that at several points different psychiatrists systematically underemphasized the affective component of the illness, with consequent underestimation of suicidal risk. Both patients were perceived as seriously ill (degree of illness), but the component of psychotic thinking was given undue prominence in the clinical evaluation at the expense of full recognition of the patients' despair (kind of illness). In describing the cases I have altered nonessential details.

Case 1. Ms. A., a 45-year-old South American woman, came to the United States when she was 30. Shortly thereafter she became pregnant and delivered a retarded son, with whom she lived in symbiotic intimacy. In the 18 months before she committed suicide she had four brief voluntary hospital admissions for what was diagnosed as a schizo-affective illness. The admissions were associated with events implying potential separation from her son and were characterized by crying, sadness, terror that she would be harmed or die, feelings of helplessness, and a wish to be cared for. Each time she responded rapidly to hospitalization and phenothiazine medication and was returned to outpatient care.

On the evening of her suicide a Spanish-speaking worker brought her to the hospital for evaluation of another decompensation, again in the context of threatened separation from her son. The worker was concerned because Ms. A. had spoken of suicide if she lost her son. Ms. A. was interviewed for more than an hour by the emergency room psychiatrist, who found her to be anxious and depressed. Ms. A. was offered a voluntary admission, but this time she declined hospitalization.

Despite the report that she had spoken of suicide earlier in the day, the emergency room psychiatrist judged her to be "not homicidal or suicidal now" on the basis of an extensive interview. Since Massachusetts law requires direct evidence of homicidal or suicidal trends for involuntary admission, involuntary commitment was not sought. Later that night she hanged herself.

Case 2. Mr. B., a 71-year-old former businessman from Puerto Rico, came to the mainland six years before his death. Following a physical illness he had developed a protracted psychotic depressive reaction characterized by intense fearfulness, delusional jealousy, sleep disturbance, and loss of his customary joie de vivre. He was treated intermittently at a general hospital for one year with a variety of medications, but with only limited benefit. His case was transferred to a neighborhood health center, where review of the case revealed he had not had an adequate trial of tricyclic antidepressant medication.

The patient and his family approved a plan for an initial course of tricyclic medication, followed by ECT if the medication were ineffective. Both Mr. B. and his family were opposed to hospitalization, which was offered. On the day of his death he slipped away from a sister who was watching him and hanged himself.

The family had been aware that Mr. B. was hopeless and wished to die; therefore, they had maintained a careful watch over him on their own initiative. The psychiatrist recognized that Mr. B. suffered from a severe psychotic depression, but he did not appreciate the extent of his despair and suicidal drive.

In neither of these cases was the individual or his family secretive about the presence of a serious illness. The translator in both cases spoke Spanish as her native tongue, was fluent in English, and had had training in school counseling. In case 1 she served as a supportive caseworker as well as a translator. In case 2 she saw Mr. B. only with the psychiatrist and did not have an independent relationship. Reviewing the cases she felt she had communicated her understanding of what the patients and their families said. As documented by the record, she brought Ms. A. to be evaluated on the night of her death out of an explicit concern that Ms. A. was considering suicide. In both cases the psychiatrists were well trained (two third-year residents in case 1 and a board-certified staff psychiatrist in case 2) and recognized that the patients were severely ill. In both cases the psychiatrist responsible had made home visits with the translator as part of the diagnostic evaluation; it did not appear that either psychiatrist was averse to working with Spanish-speaking patients. However, while all three psychiatrists diagnosed major mental illnesses requiring active intervention, none recognized the depth of despair and intensity of conscious suicidal feeling in Ms. A. or Mr. B.

A HYPOTHESIS

While two cases can at best only suggest a hypothesis, perusal of the notes kept during the course of treatment by the three English-speaking psychiatrists are consistent with a process I call "transformation of the familiar into the mysterious." In clinical terms this means emphasizing the features of psychosis (thought disorder, bizarre behavior) at the expense of observations pertaining to affect (sadness, loss of hope, despair). This process is illustrated clearly by the conclusion in the "present illness" section of the first admission note for Ms. A., written 18 months before her death.

> Ms. A. got angry, felt alone, unloved, and abandoned.... On Sunday evening and Monday morning she felt upset, was talking to herself, was disoriented, confused, feeling lonely and depressed and at times like hurting herself. She reportedly at one point attempted to choke herself. Because of this *bizarre behavior* [her friend] brought her to the hospital [italics mine].

The multiple references to a disturbed emotional state, culminating in description of a suicidal gesture, are misleadingly summarized as "bizarre behavior." The behav-

ior, all too comprehensible in the light of her ultimate suicide, was surely interpretable as a reflection of Ms. A.'s feeling of hopeless despair. The English-speaking clinician distanced himself from an evocative picture of Ms. A. by categorizing the clinical presentation as "bizarre."

A similar process is reflected in the note written 18 months later by a different psychiatrist (the emergency room officer who evaluated Ms. A. just before her suicide).

> She says she will die [if she could not have her son] but I cannot elicit a specific suicidal plan . . . she is not suicidal now. . . . Psychotic decompensation is likely in the event custody of Ms. A.'s son is taken from her.

The psychiatrist was acting under Massachusetts law in presenting evidence pertaining to involuntary commitment—in his judgment Ms. A. was not acutely suicidal. Ms. A.'s statement that she would die if she lost her son was interpreted as a sign of psychotic thought, not as an expression of despair ("I can't live without him") or of suicidal intent ("If I lose him I will die—by my own hand"). The emergency room psychiatrist, like the admitting psychiatrist one and a half years earlier, emphasized psychosis at the expense of fully recognizing Ms. A.'s affective state.

Mr. B.'s record contains numerous references to his anxiety, sleep disturbance, jealousy, and suspiciousness but never to his hopelessness or his despair. On reviewing the case after Mr. B.'s suicide the psychiatrist recalled that the translator had told him that Mr. B.'s family thought he was tired of living and wanted to die. This information, however, had somehow not guided his empathic sense of Mr. B.'s condition. The family had not denied his despair and suicidal potential, although Mr. B. ultimately thwarted their caretaking efforts (as can happen even in the hospital care of a suicidal person). The psychiatrist in the case, however, had unwittingly and uncharacteristically denied this particular aspect of Mr. B's illness.

More than 200 years ago, the philosopher David Hume observed in *A Treatise of Human Nature* (3) that empathic recognition of the emotions of another person is keen when the persons are close and dim when they are distant.

> The sentiments of others have little influence, when far removed from us, and require the relation of contiguity, to make them communicate themselves entirely. The relations of blood . . . acquaintance . . . education and custom . . . when united together, convey the impression of consciousness of our own person to the idea of the sentiments or passions of others, and *makes us conceive them in the strongest and most lively manner* [italics mine]. (p. 318)

Consistent with Hume, Schwab and associates (4) found in a recent study of medical inpatients that while amount of depressive symptomatology was inversely related to class, the presumably middle-class medical staff "is prone to ignore depression in lower-class patients" (p. 537).

In the bilingual situation the English-speaking mental health worker comes into intimate linguistic contact with the translator but not with the patient. When clinician and translator collaborate well, as appeared to occur in these two cases, there will be abundant data. However, the despair that I believe was an important part of the experience of Ms. A. and Mr. B. was not adequately appreciated by the English-speaking psychiatrists. Loss of hope and wish for death in another person is deeply painful to behold and resonate with—perhaps especially so for a health professional, whose work is so dedicated to the maintenance of life.

My hypothesis is that while translation allows transmission of data that promote diagnosis of psychosis, it may not reduce interpersonal distance enough to facilitate vivid appreciation of the patient's affective state. Because three separate clinicians (two psychiatrists with Ms. A. and one with Mr. B.) made the same clinical error independently of one another, I suggest that a tendency to avoid the pain entailed by recognizing another person's despair is abetted when clinical examination is done via translation. Because the clinicians showed good capacity to empathize with their English-speaking patients, ineptitude is not an adequate explanation, and because the process of underestimating affective pain was so similar in each case, a specific countertransference was not likely to have been operating.

CONCLUSIONS

Given the potential risks involved in underestimating the affective components of the patient's condition even while recognizing and responding to other components of the illness, I propose that mental health clinicians and their translator colleagues take special precautions. We should recognize that while translation allows effective gathering of data on life history and behavior, allowing recognition of psychotic phenomena, the process may selectively mute our recognition of the patient's despair. This leaves us with a picture of a sick person afflicted with an illness but not with the more accurate perception of a hopeless person, hating life, and moving toward choosing to end it by suicide.

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LETTERS TO THE EDITOR

Journal Shredding Strikes a Responsive Chord

SIR: Thomas Gutheil, M.D., in "Rapid Retrieval of Literature for the Practicing Psychiatrist: A Practical Approach" (October 1974 issue) noted the difficulties in constructing a usable filing system and proposed a system using an index determined by individual interests. However, there are major problems in this approach in developing appropriate subject headings and in cross-referencing.

Fuller (1) described an alternative approach based on a numerical system with all cross-referencing done within the index. Textbooks in the physician's field(s) of interest are selected for the quality and clarity of their indexes, and a reference index is constructed by assigning a number in sequence to each textbook topic. Each article to be filed is given a number from the index and placed in the file folder bearing that number. Decimals can be used to expand each topic, making the system adaptable to changing interests.

This indexing method has been used successfully to file as many as 45,000 articles, including lecture and conference notes, photostats, and reprints. It has the advantage of being infinitely expandable, flexible, and readily cross-referenced, and it is applicable to the approach suggested by Dr. Gutheil.

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SIR: I have maintained a file such as Dr. Gutheil described for about nine years. While categorization is the very basis of logic and the joys of filing are many, the problems of riddance are increased when one superimposes one's own order on the mass of psychiatric data. My file now occupies two four-drawer file cabinets and appears to be growing exponentially. Articles from newspapers and magazines find their way to rest under my forever-subdividing subject headings, and the file is marvelous for collecting material for articles one hopes to write some day, ideas for projects, etc. I would suggest the following caveats to Dr. Gutheil and to his readers starting out:

1. Old journals can be thrown away, but old files become classics that represent work and personal interest and should not be discarded.

2. Start with no file headings, just a pile of blank folders and some folding envelopes to put them in. You'll soon expand, but think small as long as possible.

3. As soon as you receive journals, tear out the one or two articles that warrant keeping. It is utter folly to shred and file whole issues—that's what libraries are for. Also, most articles are back-to-back with other articles, necessitating dilemmas of choice or of duplication.

4. Let your choices of classic articles dictate your own system of classification. Use subdivisions only as files grow too large. A general title, e.g., "Quackery," to cover all that you disapprove of but need to know about is useful at times. Keep a separate smaller file of nonpsychosomatic titles from medical journals (if you must) and throw it all away every three years.

5. Since limiting my file to two cabinets, I have discovered that getting rid of old files is extremely painful, if not impossible. To do so, I pull out some of the thickest offenders, give them a number, e.g., Law 1, and start a new file, Law 2. I then put the file numbered 1 in a box in a closet or in professional storage. If you have no recourse to these files in two years or so, they may be destroyed. Don't start a second file if the subject seems to be played out. Classic papers must be kept forever, but they can be weeded out when you have recourse to them for lectures. (Psychoanalytic journals are not easily torn apart and need not be filed. They are only quarterlies and may be kept for five years, then donated to a psychiatric library.)

6. Never tear up journals in which you have published articles. Keep special shelves for those issues, or tear up only the extra complimentary copy the editor sends you.

Interested readers who wish to learn how I miniaturized my process-note-keeping system and how I cured a recalcitrant stamp collecting habit may contact me. Please don't send complimentary reprints as an introduction.

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SIR: I have been using the device of journal shredding Dr. Gutheil described for many years. I use the numbering system in the table of contents of Freedman and Kaplan's *Comprehensive Textbook of Psychiatry* (1) as the basis of my index, assigning numbers to articles and creating new headings as needed. I mark the index number in the upper right corner of the first page of the article and the date of publication in the upper left. My file clerk then shreds the journal and files the article chronologically in the appropriately numbered folder. I can then retrieve the article by referring to the headings in my index and pulling the numbered folder.

However, the process of assigning numbers and cross-referencing takes a considerable amount of time. Consequently, my system chronically runs behind my good intentions, and I would predict that most people would have a similar problem with Dr. Gutheil's system.

If the authors of *Journal* articles were requested to assign topic headings, cross-references, and numbers to their articles in the manner I have described, my file clerk could "shred" and file the *Journal* without waiting for my input and my system would not be delayed for my most important journal.

Two more steps would make the "information explosion" more manageable. First, it would help if the *Journal* staff were to assign topic headings, cross-references, and numbers for issues within the last 10 years. Finally, and most importantly, perhaps the success of this endeavor might convince the editors of the remaining 39 publications I receive to use the same system so that their publications could be filed in similar fashion.

As an individual who obviously suffers from a hopelessly incurable variant of bibliomania, I must confess that contemplating the implementation of this system sends me into raptures.

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Editor's Note. We are most interested in these suggestions and proposals, and our staff is currently investigating the possibilities mentioned by Dr. Sones for facilitating literature retrieval. We would welcome further suggestions.

A Defense of the Nonmedical Model

SIR: I feel that the models presented by Frank M. du Mas, Ph.D., in his article "Medical, Nonmedical, or Antimedical Models for Mental Health Centers?" (August 1974 issue) are outdated and, in many ways, inaccurate and misleading.

Dr. du Mas states that group characteristics for nonmedical personnel are as follows: less ability than M.D.s, less rigorous selection, greater heterogeneity, less formal education, less rigorous training, and less scientific training than M.D.s. I think this journal has shown ample evidence that these characteristics do not apply to the Ph.D.s or M.S.W.s who have written for it. As regards training procedures, virtually all Ph.D. candidates must write dissertations in order to demonstrate research ability, whereas M.D.s generally do not. The point is that a Ph.D. has much formal and scientific training, although it is often different in kind from that of M.D.s.

Dr. du Mas states "By law and training they [M.D.s certified in psychiatry] are the only ones qualified to treat the whole person: with drugs, organically, surgically, psychologically, and socially." What other person is there but the whole person? It is absolutely untrue that qualified and licensed nonmedical personnel are not competent to treat patients psychologically and socially. Many psychiatrists treat their patients only with ECT or with prescription medication, a subject that has appeared in the pages of this journal many times.

Finally, I wonder why Dr. du Mas cited Freud's recommendation in favor of lay analysts—is he opposed to Freud's recommendation?

HANS A. ILLING, PH.D.
Inglewood, Calif.

Dr. du Mas Replies

SIR: Judging from correspondence and requests for reprints, my article is apparently being used as a teaching aid in both graduate and undergraduate courses. I wonder why such an "outdated, inaccurate, and . . . misleading" paper would be used in this way.

My generalizations about the nonmedical model are based on rational, and in some cases "mathematical," deductions. For example, a community mental health center (CMHC) I know of that operates under the nonmedical model had two full-time M.D.s, three Ph.D.s, and about 80 other personnel—a non-doctorate to doctorate ratio of 16 to 1. Service aides, therapists with B.S. degrees, etc., necessarily lower mean statistical parameters for group characteristics of nonmedical-model personnel in regard to training, IQ, clinical experience, etc. In medical-model institutions such as hospitals, doctors are the only people with final responsibility for all therapy.

Dr. Illing refers to the competency of "qualified and licensed" nonmedical people. How many personnel in the typical nonmedical-model CMHC satisfy these two criteria? I would estimate approximately 10 to 20 percent, which means that, according to Dr. Illing's own criteria, 80 to 90 percent are of questionable competence, even in psychosocial therapy.

It seems to me that Dr. Illing himself indirectly stated my own argument in his statements on the "whole person." He says that nonmedical people are qualified to treat the whole person psychologically and socially—not chemically, surgically, genetically, etc. This part of the whole person must be left to the physician.

I am not opposed to Freud's recommendation of lay analysts such as myself, provided they are sufficiently well trained to know their limitations and to place their patient's welfare first. There are few, if any, psychosocially derived symptoms that cannot be simulated by a single organic condition—organic brain syndrome. When nonmedical people treat a client without first ruling out organic, endocrinological, genetic, and other possibilities, our professional egos can literally jeopardize the lives of our clients. Therefore, M.D.s are more necessary to nonmedical mental health professionals than we are to them.

The truth hurts—unless we are willing to use it to improve our nonmedical intrusion into what has been a medical domain for centuries. Let's share our knowledge, work together, and learn from each other.

FRANK M. DU MAS, PH.D.
Augusta, Ga.

S. Weir Mitchell Rediscovered

SIR: In his paper, "Brief Therapy of Conversion Reactions: An In-Hospital Technique" (May 1974 issue), Richard A. Dickes, M.D., stated that he searched the recent literature and found no treatment approaches identical to the one he described. It is indeed true that the enormous volume of material produced, Xeroxed, and computerized these days makes it almost impossible for one to review recent as well as remote literature about anything.

Occasionally, literature from long ago can make a contribution. In 1875, S. Weir Mitchell (1) described a regime, primarily for the treatment of hysterics, that was similar to Dr. Dickes', although it was not identical. Thirty-three years later, Mitchell reported virtually a professional lifetime of experience with this treatment in an article entitled "The Treatment by Rest, Seclusion, etc., in Relation to Psychotherapy" (2). Although the "etc." included diet, massage, and electricity, Mitchell consistently put his primary emphasis on rest and seclusion.

Plus ça change, plus c'est la même chose.

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C. KNIGHT ALDRICH, M.D.
Charlottesville, Va.

Dr. Dickes Replies

SIR: Dr. Aldrich has done me and the profession a service by highlighting S. Weir Mitchell's contributions. Mitchell's approach differed from the one described in my article in several ways, the principal similarity between them being the use of bed rest and isolation. We did not duplicate the prolonged time course of bed rest Mitchell used; in fact, our patients were encouraged to ambulate as rapidly as symptoms dissipated. Mitchell often avoided discontinuing bed rest if there was an initial loss of symptoms.

We used none of the special diets, massage, or special nurses Mitchell used. Our efforts were directed toward reinforcing adaptive behavior and permitting the development of some insight.

Mitchell's patients for the most part presented well-established, long-standing symptoms, while many of our patients had symptoms of more recent onset. We therefore had to consider preventing secondary gain from fixing the symptom in mental life. It was essential to keep the hospital setting from becoming more attractive than performance on duty. Prolonged bed rest would not have served this function and, as Mitchell was aware, lengthy bed rest has its own medical complications.

RICHARD A. DICKES, M.D.
Bronx, N.Y.

Diagnosing Caffeinism

SIR: In the October 1974 issue of the *Journal*, John F. Greden, M.D., pointed out the importance of checking the caffeine intake of individuals who complain of anxiety symptoms, especially when these symptoms cannot be adequately explained by life circumstances and do not respond to ordinarily effective psychopharmacological agents ("Anxiety or Caffeinism: A Diagnostic Dilemma").

I recently saw an inmate at the Nevada State Prison who was complaining of severe anxiety symptoms that were unrelieved by high doses of minor tranquilizers or by other psychoactive agents. An inquiry about his intake of caffeine-containing substances revealed that he was consuming approximately 50 cups of coffee a day. He had a hot plate and a constant supply of coffee in his cell and, having little else to do with his time, he made and drank coffee constantly.

This patient originally expressed disbelief that his coffee intake could have anything to do with his symptoms. However, he did substitute decaffeinated coffee, cutting his total coffee consumption by 60 percent, and reported marked improvement in a very few days.

I would like to commend Dr. Greden for emphasizing the importance of this phenomenon and bringing it to the attention of clinicians.

DONALD A. MOLDE, M.D.
Reno, Nev.

Sybil: Grande Hystérie or Folie à Deux?

SIR: The proper diagnosis for multiple personality is grande hystérie, according to Dominick A. Barbara, M.D., in his review of *Sybil* (August 1974 issue). But the French have given us a still better diagnosis for this case—folie à deux. It is clear that the 16 selves said to be inhabiting Sybil's body were as real to her psychoanalyst as to Sybil herself. In fact, most of the time Sybil refused to accept their existence, while the analyst believed in their reality, even claiming to see and speak to them.

Thus one of the novelties in this case is that the analyst tried for years to persuade the patient to believe in a complex delusional system. One can only wonder how often this happens. Perhaps the publication of *Sybil* will encourage others to reveal their unconventional therapeutic techniques. This possibility lends support to Dr. Barbara's suggestion that *Sybil* "is destined to stand as a significant landmark in psychiatry and literature."

We know that psychiatry as popular literature often resembles a fairy tale, and *Sybil* is no exception. Even though the book seems to be intended for a youthful audience, serious inferences may nonetheless be drawn from it.

I would suggest that the likelihood of a diagnosis of multiple personality (or grande hystérie) being made is positively correlated with the romantic and fanciful tendencies of the diagnostician.

It is a kindness that Freud did not live to see Sybil's fairy godmother identified in a scholarly psychiatric journal as a psychoanalyst engaged in psychoanalysis of an "essentially Freudian" orientation.

GEORGE VICTOR, PH.D.
Livingston, N.J.

Dr. Barbara Replies

SIR: Dr. Victor's letter is a distortion of fact. He should know that multiple personality, an established medical entity, is not a "complex delusional system" or a delusion at all on the part of either the therapist or patient. The alternating selves provide a system of dissociation whereby the waking self is defended against intolerable and therefore buried emotions. Sybil was amnesic for parts of herself—the alternations—because they carried the burden of the memories she had repressed and denied. The alternating selves are thus the objectification and acting out of repressed materials, the usual arsenal of psychoanalysis. To say that "most of the time Sybil refused to accept their [the alternating selves'] existence, while the analyst believed in their reality—even claiming to see and speak to them" is to misunderstand the dynamics of the case. Sybil refused to accept the existence of the memories she denied and therefore, by definition, the unconscious caretakers of those memories. On the other hand, Dr. Cornelia B. Wilbur, the analyst, could talk to these alternations not because she had deluded herself into being able to do so, but because "they" were parts of her patient. She not only talked to them but sometimes recorded what they said. There is nothing fanciful, mystical, or delusory about the "they," who represented dissociated parts of a real person.

These parts, however, were differentiated by self-image, by the way they functioned, and by their speech. Flora Rheta Schreiber, the author of *Sybil*, is a professor of speech at the City University of New York's John Jay College of Criminal Justice. Listening to the tape recordings of Sybil's alternations as part of her herculean research, Prof. Schreiber noted differences in the alternations in diction and accent, as well as in vocabulary, grammar, and intonation. Why, since the selves are part of Sybil, do they speak with different voices? The answer is that the selves, on certain levels, were identifications with people in Sybil's life, and their voices coincided with the person with whom the identification was made.

Contrary to what Dr. Victor says, it is too bad that Freud is not alive to read *Sybil*, which epitomizes some of his deepest

convictions. The unconventional psychoanalytic techniques of Sybil's therapist are reminiscent of those he himself employed in his patients' analyses. In fact, Prof. Schreiber quotes Freud as follows:

> The whole multiplicity of the problems of consciousness can only be grasped by an analysis of the thought-processes in hysteria .... Examples of every possible variety of how a thought can be withheld from consciousness or force its way into consciousness under certain limitations are to be found included within the framework of psycho-neurotic phenomena.

She then adds, "If you translate 'thoughts' into 'secondary selves,' you have the analog [of the case of Sybil]" (p. 349). In conclusion, far from dealing with the fanciful, *Sybil* works within the framework of established Freudian concepts.

DOMINICK A. BARBARA, M.D.
Lawrence, N.Y.

In Appreciation of the "New Chairman"

SIR: This is a heartfelt word of appreciation for Dr. Arnold Mandell's witty and penetrating analysis of the recent history of psychiatric education, particularly of the radically altered role of the departmental chairman ("The Changing Face of Chairmen of Psychiatry Departments in America: An Opinion," October 1974 issue).

As one of the many academic psychiatrists who have consistently declined chairmanship offers—and for the very reasons so incisively stated by Dr. Mandell—I heartily concur that today's chairman is and should be a different breed of cat.

Chairmanship search committees would be well advised to seek candidates with demonstrated managerial talent and political adeptness. I quite agree that there is little reason to expect the return of the charismatic, life-tenured "grand old man" chairman of the pre-1950s era. However, I cannot help but wonder if a great share of the teaching responsibility in psychiatry will not soon be recovered by a cadre of biologically and medically oriented, eclectic, experienced, and humanistic "grand old men" (or, at least, "good old guys").

If this happens, they will certainly need all the support and protection they can get from Dr. Mandell's "new chairman." This person may not be celebrated for his contribution to the literature or his teaching or clinical abilities, but those of us who are privileged to work under the direction of someone with the managerial virtues described by Dr. Mandell can approve and appreciate the talents he does have rather than vilifying him for those he does not. It is to be hoped that we will soon stop looking upon the chairman as a necessary evil, regarding him instead as a truly necessary and welcome person.

DONALD J. HOLMES
Carefree, Ariz.

Credit Where Credit Is Due

SIR: I read Dr. Stanley Greenspan's article "The Clinical Use of Operant Learning Approaches: Some Complex Issues" (August 1974 issue) with enthusiasm. He concisely phrased observations about behavior therapy that I have labored to clarify. However, I was startled that he did not recommend help from psychoanalytic knowledge to accomplish the necessary task of "understand[ing] the entire behavior pattern of an individual." His language is, with one exception, devoid of psychodynamic terms. The general concepts and problems he outlined have long been known and understood by psychoanalytic and psychodynamic psychotherapists, and many of his points are restatements of their knowledge.

In asserting that the question of what should be treated involves both the therapist's input and the patient's choice of the areas he wants to work on, Dr. Greenspan noted that this mutual choice is made from a position of understanding the patient's total personality. This requires sufficient nondirective therapy to allow continuous reevaluation of goals; psychoanalysts might call this "listening with the third ear." Dr. Greenspan's structuring of a series of small, gradual steps involving changing goals that lead to desired results might be spoken of as working through successive layers of resistance and/or maturational phases. Being locked into a particular behavior because of prematurely rigid goals resulting in a compromise of the patient's attainment of true autonomy may be thought of as an impasse in treatment caused by countertransference.

Such comparisons transposing clinical or theoretical material from behavior principles to psychodynamic principles and back is easy to do and has become a frequent exercise for students. My point is simply that justice should be done to one's trailblazers.

However, Dr. Greenspan undoubtedly used good judgment in not including such comparisons in his article, as doing so would have encumbered and perhaps detracted from his thesis and might have irritated some of his readers. Nevertheless, I would like to acknowledge the psychodynamic formulations of the clinical observations Dr. Greenspan describes in behavioral language.

R.W. BURGOYNE, M.D.
Los Angeles, Calif.

Dr. Greenspan Replies

SIR: I would like to thank Dr. Burgoyne for his perceptive and sensitive comments. As he suggests, my discussion of operant learning techniques derives in part from an understanding of personality organization stimulated by psychoanalytic concepts and methods of exploration. He is also correct in assuming that I avoided explicitly stating the psychodynamic contributions and points of comparison in the interest not only of clarity and conciseness but of communication with mental health professionals who do not use psychodynamic formulations.

Most importantly, I tried to demonstrate the complexity of behavioral phenomena in strictly behavioral language to avoid the dichotomies stimulated by theoretical comparisons and to show that an understanding of the intricacies of behavior is essential, regardless of one's orientation in theory or practice.

I have, however, attempted to deal with the theoretical and practical comparison and integration of behavioral learning and psychoanalytic models and techniques in other works (1–3).

I would like to thank Dr. Burgoyne again for his helpful comments.

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STANLEY I. GREENSPAN, M.D.
Washington, D.C.

A Perceptive Patient

SIR: I was recently reminded of something we were all taught as residents—the need to choose our words carefully when speaking in front of catatonic patients, who are far more aware of their surroundings than their outward appearance suggests. On my daily visit to a physically ill, very deaf, and almost blind 74-year-old catatonic patient, I waved my hand and put on a broad smile as I approached. I then leaned close and shouted my "good morning." She broke her usual silence with the only sentence of her day: "You have been eating onions."

WILLIAM L. CLOVIS, M.D.
Philadelphia, Pa.

On the Rationale and Consequences of the "Illness" Label

SIR: While reading Seymour Kety's "From Rationalization to Reason" (September 1974 issue), I was reminded of the standard response of any bureaucrat when he is challenged on why he is performing a particular function: "I don't make the rules, I only follow them." Dr. Kety follows the rules of scientific methodology scrupulously, but apparently he has chosen to ignore the implications of his research and commentary.

There may well be a set of behavioral responses determined by genetic as well as environmental and psychological factors that can be accurately recognized and labeled as the "illness" of schizophrenia, but any personality trait, attitude, cognitive style, etc., may have genetic components, just as there may be a genetic predisposition to diabetes. However, this begs the question: What should be done about this set of responses? Dr. Kety goes along with the rules, and labels the set an "illness." Well, homosexuality was an illness yesterday; what is it today? Marijuana use is a symptom of an "illness" today; was this the case before the Marijuana Act of 1937? And what will society call it after it has been decriminalized?

Neither rationalization nor reason will change current societal attitudes toward illness. While society's response to one who is "ill" may range from revulsion and fear to pity and compassion, all of these responses imply some form of avoidance or distance. As Dr. Kety repeatedly emphasized, illness is to be prevented, conquered, treated, and eliminated, but the implication is that it is never to be tolerated. Is this a therapeutic attitude toward schizophrenic patients?

The comparison of schizophrenia with diabetes is a weak tactic to avoid the implications of illness labeling. Not only are the sequelae of untreated diabetes entirely organic in origin, but they are unaffected by societal attitudes toward diabetes. Insulin, not society, determines the course of diabetes. Can the same be even intimated for schizophrenia?

It should be noted that Dr. Kety's conclusions are cautious and well founded. But what would the information that there is a clearly demonstrable genetic predisposition to schizophrenia lead society to do? He implies that this question will not be asked or, if asked, that it should be answered by someone other than psychiatrists. After all, he tells us that "psychiatry is in an identity crisis precisely because it has branched out beyond mental illness into problems it is not especially qualified to handle. . . ." I submit that if we do not anticipate these questions and attempt to answer them within a frame of reference consistent with our profession, we are not only evading responsibility for the knowledge that we generate, we are leaving the answers to be formulated by members of other professions, such as politicians or policemen.

Computers, questionnaires, and kappa values may exist in a social vacuum, but my patients do not. While I applaud the excellent research conducted by Dr. Kety and others attempting to explain schizophrenia, I believe that focusing solely on "the salutary consequences that are an inherent part of the medical model . . ." and denying or ignoring the consequences for the individual when schizophrenia is labeled an illness is to perpetuate psychiatry's "identity crisis" with rationalization rather than with reason.

THOMAS J. KAISER, M.D.
Camarillo, Calif.

Misspellings and the Potential for Violence

SIR: I wish to comment on Dr. Bernard L. Diamond's review of my book, *The Murdering Mind* (September 1974 issue). Dr. Diamond is quoting me out of context when he mentions that I list habitual misspellings as probably relating to a potential for violence. Misspelling in and by itself is not a sign of potential violence. What I have said is that this sign in conjunction with others may be an indication that an individual may later become violent. I have also mentioned, as Dr. Diamond states, that the signs listed may also indicate emotional disturbances that do not necessarily result in murder. As I stated in *The Murdering Mind*:

> The spelling errors are measurable symptoms which can, if confirmed in large-scale research data, be used as a means of detecting the potentially violent or murderous person. Where in addition we find habitual truancy and other early symptoms, as mentioned before, we must be on the alert for latent violence. (p. 28)

A more serious problem is that Dr. Diamond did not mention the main thesis of my book, the intimate connection so often found between murderer and victim—the concept of victimology—"a link . . . which is most often overlooked or simply omitted when a case comes to trial." This oversight is most regrettable.

DAVID ABRAHAMSEN, M.D.
New York, N.Y.

Messages of the Body, *by John Spiegel and Pavel Machotka. New York, N.Y., Free Press (Macmillan Publishing Co.), 1974, 426 pp., $17.95.*

This well-written book presents a method for studying how body movements, gestures, and postures function in human communication. It also reports on some experiments designed to show the effectiveness of this method.

In the first three chapters, Dr. Spiegel reviews the literature on the function of body movements in human communication. One chapter is devoted to dance and another to mime. In the fourth chapter, he presents an excellent summary of the various scientific research strategies that have been used to study nonverbal communication. He specifically criticizes the idea that body communication functions in an analagous way to verbal communication.

Dr. Spiegel presents his system for organizing and categorizing body movements, which he terms "presenting behaviors," and defines as consciously or unconsciously intentional arrangements of stimuli emitted in the presence of another person to evoke a desired response. He stresses the point that, although presenting behaviors function as observable links between internal processes and external situations, they can be studied independently of both the inner state of the organism and its external situation.

In the following chapters, Dr. Spiegel develops hypothetical categories for organizing and describing presenting behaviors as they occur consecutively through time.

The concept of presenting behaviors is central to the book's method for studying nonverbal behavior. Linguists have called what Dr. Spiegel calls a presenting behavior an element in the structure of expression (1). This concept has been an important part of the linguistic method.

In chapters 9 through 16, Dr. Machotka presents the results of some experiments designed to test the usefulness of Dr. Spiegel's hypothetical categories for organizing body presentations. Dr. Machotka studied how line drawings of certain body behaviors were interpreted by a series of subjects. These subjects were asked to compare the meanings of drawings of human figures in systematically varying body presentations along several measurements using Osgood's Semantic Differential Scale.

The data indicate the meaning the subjects attached to each specific alteration in body presentation. This method was used to study such presentations as genital-covering versus genital-exposing arm and hand positions, clothing versus nudity, and the effect of the direction of gaze on dominance within a group of people.

In chapter 17, Paul Williams reverses the method used by Dr. Machotka. He asks subjects to position flexible wooden manikins to create body configurations that would communicate the specific idea or affect found by the subjects in Machotka's experiment.

I have two major criticisms of this book's method for studying nonverbal communication. First, the categories used to organize and describe presenting behaviors were selected a priori on the basis of theoretical assumptions. Second, the presenting behaviors themselves were arbitrarily selected from classical paintings.

The book shows, however, that statistically reliable data can be compiled by the method described by Dr. Spiegel. The data themselves provide a useful estimate of the meanings of the roughly defined presenting behaviors. This book is a welcome addition to the literature on nonverbal communication.

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FELIX F. LOEB, JR., M.D.
La Jolla, Calif.

About Behaviorism, *by B.F. Skinner. New York, N.Y., Alfred A. Knopf, 1974, 256 pp., $6.95.*

In the introduction to this volume, B.F. Skinner refuses to accept the mantle of *the* behaviorist that was worn by John B. Watson in the early part of this century. Despite this disclaimer, it appears to me that this mantle has been popularly bestowed upon Skinner and, like Watson, he is reaping its benefits, both positive and negative.

It is very stylish to be either for or against B.F. Skinner and whatever it is that he represents. In order to broadly conceptualize an entire body of information on contingencies of reinforcement, it is probably easier to subsume it under a single name, thus placing Skinner alongside Darwin, Newton, Freud, and many others who have been chosen to represent a particular thrust in science or philosophy. What is often lost in this global generalization is the actual contribution and thoughts of the man. Instead one sees a conglomerate of widely varying contributions, often by many of lesser talent, that are attributed to the man himself.

In most instances, comments concerning a "Skinnerian" view of human behavior do not reflect Skinner's work or thoughts but those of many investigators who use some of his ideas to approach a diversity of human problems. Nowhere is this clearer than in Skinner's concern about the use of aversive stimulation, the influence of a deprived environment on social behavior, and the use of behavioral strategies on captive populations. His approach to these phenomena is inferred from the application by others of behavioral principles to self-destructive children, prison populations, juvenile detention facilities, and the retarded, but they are not derived from Skinner's actual behavior. Skinner's being called fascist, antidemocratic, a pseudoscientist, and a dehumanizer is based on presuppositions that bear little relationship to his experimental work and extrapolations to human behavior and its vicissitudes. Thus it is important that *About Behaviorism* is written by Skinner himself to correct some misapprehensions about what he represents and what contributions radical behaviorism can make to the understanding of human behavior.

The essence of this volume is an explication of 20 commonly held assumptions about behaviorism, including such diverse notions as that it ignores consciousness and feeling states, that it is dehumanizing, antidemocratic, and scientistic, and that it reduces man to an automaton, neglects innate endowment, and does not account for cognitive processes. Although Skinner takes issue with many who represent these positions, he does

not disregard their findings. Rather, he suggests that the data can be examined from a much more economical perspective by examining actual behavior in the context of contingencies of survival and reinforcement rather than through the perspectives of "humanism," "mentalism," and various forms of "structuralism." His arguments are compelling as he lays about in all directions to unhorse a group of authors whom he does not mention by name but about whom he states,

> I express my regrets if the authors would have preferred to be given credit, but I have applied the Golden Rule and have done unto others what I should have wished to have done [to me] if I had used such expressions.

It does not take a great deal of imagination to recognize whom he is criticizing for using a mentalistic or structuralistic approach to human behavior when he discusses innate language mechanisms (Chomsky), ego, id, and superego conflicts (Freud), developmental unfolding (Piaget), and stages in the life of man (Erikson), to name a few. Nevertheless, his arguments are soundly reasoned and provide an extremely interesting view of human behavior, although the terms used to describe it do not carry the impact of the pathetic fallacy in literature or the commonly used phrases that endow man with a mental life glowingly called a thing of wonder and beyond all comprehension. As Skinner points out, this latter view stops all investigation of behavior and closes a neat tautological ring.

One prerequisite for reading this book is some knowledge of the strategies and definitions of reinforcement learning. Another is an open mind to more parsimonious explanations of human behavior. There are some areas where one could take issue with Prof. Skinner. Despite his denials, he studiously avoids the "between-the-skin" space of the human being. He thus runs the risk of being unable to account for certain human peculiarities that in medicine are more obvious through their pathology than through their usual characteristics. Here I refer to the peculiarities of schizophrenia, manic-depressive disease, organic brain syndromes, childhood psychosis, and aphasia, where the usual operating contingencies of survival and reinforcement are uniquely distorted by what exists between the skin.

Despite this reservation, I am strongly compelled by Skinner's arguments. It appears to me that his approach to understanding human behavior will probably assume greater significance in the long run. For those who have an open mind concerning B.F. Skinner, this book should clearly show him as the consistently behaving philosopher of science who nonetheless is an obvious romantic who can enjoy being human without having to explain it beyond his data.

JAMES Q. SIMMONS III, M.D.
Los Angeles, Calif.

Mental Health Care in the World of Work, *by Hyman J. Weiner, Sheila H. Akabas, and John J. Sommer. New York, N.Y., Association Press, 1973, 182 pp., $8.95.*

Since the literature on mental health research in a work setting is sparse, the project described in this book is of special interest. Funded by the U.S. Department of Health, Education, and Welfare, the project involved workers in the men's clothing industry in New York City. Its primary focus was to offer mental health services to persons who found that emotional illness was hindering their job performance; the goal was to maintain them on the job, or, if they had stopped working, to return them to the job.

The authors do not suggest a cause-effect relationship between the work setting and mental illness. Rather, they see the work environment as relatively neutral, even though many of the jobs in the men's clothing industry are mechanical and repetitive and there is a great deal of pressure to produce (most employees are paid on a piecework basis).

One of the important findings of the research is that many mentally ill persons can continue working. "We were constantly amazed," the authors observe, "by the way in which women and men with severe emotional disorders were able to function on the job" (p. 156). Noting that psychiatric case histories from other settings are replete with examples of workers who fell by the wayside, they suggest that "modest efforts at intervention could influence this tide" (p. 156).

As far as actual treatment was concerned, the researchers found that in psychotherapy these blue-collar workers were usually verbal and expressive, were able to develop a capacity for self-awareness, and often rejected psychotropic drugs as potentially habit forming. The authors had the impression (shared by those who have treated blue-collar workers in other settings) that the active, directive therapist is somewhat more successful than the one who adopts a relatively passive therapeutic posture.

The authors observe that ours is one of the few industrialized countries lacking a work-rehabilitation philosophy; the present system is one in which a vocational counselor usually places an individual on a job *after* his treatment program is completed. They advocate a view that "sees the world of work as the context and partner in the rehabilitation process" (p. 156).

Not all of the experience gained in this project can be generalized to other work settings. Both the men's clothing industry, with its many small manufacturers, and the Amalgamated Clothing Workers union, whose representatives assisted in involving the mentally ill workers in treatment, have some characteristics that make the situation described by these authors unique. But this book will be useful to all those treating blue-collar workers and also to those involved in setting up comprehensive mental health programs in many kinds of settings.

EVELYN S. MYERS
Washington, D.C.

Benzodiazepines in Clinical Practice, *by David J. Greenblatt, M.D., and Richard I. Shader, M.D. New York, N.Y., Raven Press, 1974, 293 pp., $14.50.*

Since they became clinically available in 1960, the benzodiazepines have emerged as the most frequently prescribed psychopharmacological agents for the distressing symptoms of anxiety. During one year's time, at least 1 in 10 Americans takes a benzodiazepine tranquilizer or hypnotic. There is therefore an obvious need for a concise review of the voluminous literature on these agents—ranging from their pharmacological properties to their clinical indications and usefulness.

Drs. Greenblatt and Shader have splendidly distilled the literature on benzodiazepines into a succinct volume that provides an excellent rational therapeutic guide for the practicing psychiatrist. They have reviewed the entire English literature on the benzodiazepines; 2,000 references are critically reviewed and incorporated into this volume. Yet this is not a ponderous reference work that focuses on minute details. It addresses itself directly to clinical therapeutics.

The book consists of 13 sections, 6 special appendices, and an index. Three sections provide a concise review of the biochemical, neurophysiological, neuropharmacological, and behavioral

pharmacology of the benzodiazepines. The authors cite what is known and what is conjectural at this time.

The remaining sections—the bulk of the book—focus on treatment, indications, and experiences. The roles of the benzodiazepines in emotional disorders, neuromuscular and seizure disorders, sleep disturbances, alcoholism and other drug-dependent disorders, and surgical procedures (i.e., anesthesia) are sequentially reviewed.

The authors also review the effects of the benzodiazepines on organ systems and their relationships to experimental stress and performance. These two sections splendidly combine the applied psychopharmacological aspects of these agents to the body as a whole. They deal with effects of the drug on the different organ systems and on their allied performance boundaries. In uncluttered terms, the book notes that the benzodiazepines have few effects beyond the central nervous system. Accordingly, they can be used in the psychophysiological disorders to alter the target symptoms of anxiety without interfering with the status of the major organ systems—truly a blessing in the terribly complex management of so-called psychosomatic disorders.

The section on stress pinpoints the noted physiological dysfunctions (i.e., reaction time, coordination) of specific bodily reactions to the drug. Side effects are reviewed thoroughly; both tentative and firm guidelines are provided. There is a large abuse potential with the benzodiazepines, and the authors clearly document and underscore this dimension. This particular section is a model of all the sections of this book: the material is presented in a clear, concise, and unbiased fashion replete with a concluding summary that synthesizes the essentials of this aspect of the benzodiazepines.

This is a superb book, one that I believe will become a model for future reviews of the clinical "state of the art" of specific psychopharmacological agents. The two authors have brought together a ready resource guide for the psychiatric practitioner, family physician, and trainee. It should be read by all colleagues who pride themselves in keeping abreast of the major treatment approaches in modern psychiatry.

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Mental Health Programs for Preschool Children: A Field Study, *by Raymond M. Glasscote, M.A., and Michael E. Fishman, M.D. Washington, D.C., Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1974, 182 pp., $7.00.*

This is an extremely important book for people concerned about young children and the programs available to them when they are in need. If it is true that 1 out of 10 children will be considered emotionally impaired sometime during their childhood, then such programs are not a luxury but a necessity.

This descriptive study of seven mental health programs for preschool children, the twelfth in a series by the Joint Information Service of the American Psychiatric Association and the National Association of Mental Health, is an extension of a study of children served in community mental health centers (1). It was found in the previous study that only 2 percent of the children served by eight community mental health centers were of preschool age. This current study was undertaken to raise the level of awareness of needs for this age group. It eminently succeeds in this endeavor.

The book is divided into two parts. The first is a summary of more than 300 articles dealing with emotionally disturbed young children and the emotional needs and development of all young children. Some of the works of Piaget, Provence, Eisenberg, Erikson, Rabin, Roberts, Rowley, Fraiberg, Kanner, Anthony, and many others are condensed and organized by topic. Areas covered include principles, needs, the mother, beyond home and mother, and emotionally disturbed children. The section is brief, concise, and well written. It provides the background and principles for the major part of the book, which details the programs themselves.

Included in part 2 of the book are detailed descriptions of the Dubnoff Center for Child Development in North Hollywood, four interrelated programs in Topeka, Project Enlightenment in Raleigh, the Development Center for Autistic Children in Philadelphia, the Martin Luther King, Jr., Parent-Child Center in Baltimore, the Division of Child Psychiatry of Cedars-Sinai Medical Center in Los Angeles, and the Preschool Unit of the Cambridge-Somerville Mental Health and Retardation Center in Massachusetts. These centers were selected on the advice of "reliable people" and represent different goals, orientations, and philosophies. Each center is discussed in terms of its history, eligibility, geographic area served, philosophy, rationale, system employed, and administrative functioning. The latter includes a discussion of such areas as funding and record keeping, staff, physical plant, program, evaluation, and aspirations.

After reading these descriptions, one feels intimately familiar with each center—its achievements, concern for children, creative and resourceful use of facilities and manpower, and frustrations. What becomes very clear is the need for follow-up and outcome studies to evaluate what is being done or not being done and the complex, often inadequate funding available to such centers. The demand of funding agencies to know results before they will fund programs, even though such programs seem right and are administered by competent, compassionate people, precludes a ready source of money. Added to this, of course, is the low priority our country generally gives to preschool children.

Most of the centers described are in a dilemma. They have barely enough funds to maintain their standards of care, let alone do outcome studies, which are becoming increasingly necessary for further funding. Few programs across the country have the luxury of built-in funds for longitudinal follow-up and outcome measures. At least one exception, fortunately, is the Brookline Early Education Project (2), which, however, deals with a general population of preschool children in terms of early educational intervention and identifying children at risk. This center follows children from birth to second grade. The study is done on a careful cost-accounting basis and outcome is a major part of the work. Such studies are needed for children identified as emotionally disturbed or at risk.

If we assume that psychological intervention makes a difference and that the earlier the intervention the more favorable the outcome, priority must be given to these young children. Comprehensive services for the preschool child and evaluation of such services must be funded and provided. Humanity demands it; science demands it.

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The International Pilot Study of Schizophrenia, vol. 1, *by the World Health Organization. Geneva, Switzerland, WHO, 1973, 412 pp., 56 Swiss francs (paper).*

The origins of this massive transcultural study date back to 1959, when the World Health Organization (WHO) convened an expert committee on the epidemiology of mental disorders. This committee stressed the need for reliable and valid data on the incidence and prevalence of mental disorders and recommended WHO assistance in the international coordination of studies aimed at solving problems of observation, classification, recording, counting, and research design.

Later publications and meetings led to a meeting of a WHO scientific group in 1964 that recommended the development of methods necessary to carry out transcultural research in psychiatric epidemiology. In subsequent years the initial plan for the International Pilot Study of Schizophrenia (IPSS) was worked out and funds were made available by the U.S. National Institute of Mental Health (NIMH) as well as by WHO and the collaborating field research centers.

The IPSS is part of WHO's long-term plan in psychiatric epidemiology and social psychiatry designed to implement the recommendations of the scientific group. This plan has four interlinked programs. Program A is concerned with the standardization of psychiatric diagnosis, classification, and statistics. Program B is intended to determine whether comparable cases of mental disorder can be identified in various populations throughout the world. Program C was seen as developing out of Program A and B and will consist of comprehensive epidemiological studies of specific mental illnesses in defined populations. Program D, also planned as a development of the earlier programs, will be an international research training program in psychiatric epidemiology and social psychiatry.

The aims of the IPSS, the major vehicle of Program B, were to seek answers to such basic questions as the following:

1. In what sense can it be said that schizophrenic disorders exist in different parts of the world? Do they differ in form or content? Does the clinical course differ?
2. Can other functional psychoses also be recognized? Do they run a recognizably different course?
3. Can techniques be developed for recording and classifying symptomatology reliably?
4. Can teams of research workers be trained to use these techniques so that comparable observations can be made in both developed and developing countries?

The design was that of a prospective follow-up study, with cases selected by a series of screening procedures and examined with standard instruments in nine field research centers located in different parts of the world. A modified version of Wing's Present State Examination (1) was the major psychiatric rating measure. This was carefully translated into the eight languages used by the collaborating investigators. Over 1,200 patients were included in the study, and approximately 1,600 items of information were obtained for each patient. Thus about 2,000,000 items of information had to be condensed into comprehensible proportions by a complex set of procedures.

This volume details practical information on the management and operation of the project from its inception. There are chapters describing the instruments; the problems of translating psychiatric terms into languages as diverse as Chinese, Czech, Danish, Hindi, Russian, Spanish, and Yoruba; the methods of statistical analysis; the characteristics of the patients; and several methods of classification, including cluster analysis and clinical classification by computer.

The results of the study show that the procedures chosen were adequate to find schizophrenia, manic and depressive psychoses, and neuroses in the nine field research centers. The study also shows that the techniques used permit studies of schizophrenia to be carried out in different parts of the world with the assurance that results will be comparable. It was evident that similar groups of schizophrenics could be found in each of the nine centers, that valid and reliable research instruments could be developed for practical use in international psychiatric studies, and that teams of psychiatrists and other mental health workers from different theoretical backgrounds and widely separated cultures and socioeconomic conditions could collaborate in a large-scale international study.

This report presents the results of the detailed initial evaluation phase only; follow-up evaluations at one and two years will appear in the future. The reader will be impressed by the scale of the study, the years of planning needed to ensure its success, the sheer volume of the data, and the intricate methods of statistical analysis. The international network of centers in countries at various stages of development can serve as a basis for future research and training in psychiatric epidemiology. It is to be hoped that funding will be available to continue research at these centers.

This volume is reproduced by photo-offset from typescript and paperbound in an unsewn binding. This has the advantage of inexpensive and rapid production but the disadvantage of impermanence; the pages cannot be expected to remain in the binding after one thorough reading, and library shelf life is likely to be short. If subsequent reports are to be similarly produced, the collaborating investigators should be encouraged to prepare a hardbound volume to ensure the survival in print of this milestone of research in psychiatric epidemiology and social psychiatry.

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A. ARTHUR SUGERMAN, M.D., MED.D.SC.
Belle Mead, N.J.

Changing Human Behavior: Principles of Planned Intervention, *by Ralph K. Schwitzgebel and David A. Kolb. New York, N.Y., McGraw-Hill Book Co., 1973, 318 pp., $10.50.*

The main thrust of this book is the concern of the authors about the spiraling quantity of work being done with regard to human behavioral change, the lack of established basic guidelines, and the need to upgrade the overall quality of this output. The authors claim to espouse no particular therapeutic approach but, rather, to formulate basic principles for planned intervention into human systems.

They formulate the following principles: 1) intervention in human systems should be based on scientifically verified principles of behavioral change; 2) the behavior should be empirically defined and observed over a reasonable length of time; 3) procedures should be explained in ways that can be replicated by others; and 4) application of behavioral change should be directed toward meaningful and personally significant human behaviors as opposed to contrived laboratory situations.

The book itself is divided into two basic parts. The first deals with specific theoretical approaches, their historical evolution, and suggested areas for further investigation. While many of these techniques are associated with "behavioral modification," the authors' use of the terminology is oriented toward research.

The second section of the book deals with such research-oriented considerations as observation and recording of behavior, assessment of change, and ethics associated with human experimentation and manipulation.

The authors are to be commended for their efforts to present a measured appraisal of the field of behavioral change. The book is knowledgeable, well referenced, well organized, and readable. While the first half of the book would appeal more to the neophyte, the second half is more interesting to the trained behavioral scientist because it clearly delineates the pitfalls of human research and injects a note of humanity and human dignity.

With the increasing encroachment of third-party-payment organizations into the physician-patient relationship, demonstrable efficacy of treatment will be of vital importance in the future. This book raises important questions about the present state of the behavioral sciences and provides valuable guidance for continued refinements of research techniques geared toward achieving a more meaningful body of knowledge. While this book would have limited appeal for the full-time clinician, it should be required reading for anyone dealing in behavior change research.

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The Lesbian Myth, *by Bettie Wysor. New York, N.Y., Random House, 1974, 428 pp., $8.95.*

This book should be of interest to many members of APA in light of the recent ruling by the APA Board of Trustees that homosexuality "by itself does not necessarily constitute a psychiatric disorder" and that changed the listing of homosexuality in the *Diagnostic and Statistical Manual of Mental Disorders* (second edition) to "sexual orientation disturbance." Ms. Wysor's theses, as stated in the introduction, are as follows:

> My research into the subject [lesbianism] had convinced me that there is actually no such thing as heterosexuality or homosexuality; there is only *sexuality*, upon which has been imposed a social and moral structure which demands sharply defined sex roles and ritual sexual behavior. . . .
>
> Only when people of varying life styles feel free to come into the open—where they can exhibit their humanness, their worth and their usefulness to society—can people get to know them, stop mis-imagining, and realize that they can accept people who chose a different way of life without any threat to themselves or society. (pp. xi, xii, xvi)

The book is divided into two parts. Part 1 deals with "The Scholars: Theology, Science, Literature" and part 2 deals with "The People: Discussions Among Lesbians."

Part 1 is thought provoking and interesting, especially its first four chapters. The author has obviously devoted a good deal of time to careful research on the biblical sources of many contemporary ideas and attitudes. These chapters and the bibliographic documentation held the most interest for me. The remaining two chapters, on "Psychiatry, Homosexuality and Bisexuality" and "Lesbianism in Literature," are more pervaded by Ms. Wysor's particular point of view.

Part 2 consists of four tape-recorded discussion groups, one of which was a therapy group. Approximately 30 different women who have fully or partially adopted the lesbian lifestyle took part in these discussions. The chapter titles in this section are often misleading in that they represent the topic on which the leader had hoped to focus. All of the women lived in the area of New York City and most seemed to be of upper-middle-class background. This lack of heterogeneity left me with many doubts about the representativeness of their experience and views.

Undoubtedly, as we move into the last quarter of this century psychiatrists will encounter many more patients who are openly bisexual and homosexual in their personal practices. Ms. Wysor's book may provide a starting place for those who wish to consider such patients and their sometimes deeply troubling problems. It also offers us a chance to hear first-hand the thoughts of some lesbian and bisexual women who do not see themselves in the role of patient.

NANCY A. DURANT, M.D.
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From Diagnosis to Treatment: An Approach to Treatment Planning for the Emotionally Disturbed Child. Report 87, *by the Committee on Child Psychiatry, Group for the Advancement of Psychiatry. New York, N.Y., GAP, 1973, 146 pp., $4.00 (paper).*

This volume on treatment planning is one of a series of reports formulated by the Committee on Child Psychiatry of the Group for the Advancement of Psychiatry. A broad view of treatment is taken by the committee, the term being used to encompass "an extended range of curative, ameliorative, and health-promoting procedures." Treatment planning is defined as "the process which takes place between the diagnostic formulation and the ultimate treatment recommendations."

The principles of differential treatment planning, the assessment of therapeutic potential, and the communication of diagnostic findings and therapeutic recommendations are discussed clearly and concisely. Of particular value, in my opinion, is the stress laid on the role of the community. The need to assess the therapeutic potential in the child's community, the need to accurately communicate diagnostic findings and therapeutic recommendations to the referring source in the community, and the need for a working knowledge of community resources are all properly emphasized. A model of how to attain this latter knowledge is presented by the Ginsburg Fellow on the committee in a personal account of his efforts to ascertain the assets of his community on first entering practice as the only child psychiatrist in a midwestern state.

The chapter presenting different treatment plans formulated for the same cases by consultants from markedly different clinical settings makes for stimulating and worthwhile reading, as does the chapter outlining 14 common stereotypes and misconceptions about the psychiatric treatment of children. However, it appears to me that some of these stereotypes may be actually maintained in some sections of this report.

For example, one stereotype listed is "Rapid symptom removal is bad." Yet symptom removal is not mentioned as one of the goals of therapeutic intervention (p. 604), and it is stated that on occasion symptom removal "does not allow us to get at the cause of the symptom, and the cause will then find another outlet." Evidence in the literature for such symptom substitution is lacking.

"The only good therapy is psychotherapy" is another stereotype listed. However, a good deal of what is discussed in the volume would appear to apply primarily to dynamically oriented psychotherapy. Statements like the following would seem to indicate that emotional problems of children can be conceptualized only in a dynamic framework: "Families deserve the pre-

sentation of a dynamic formulation . . ." (p. 591); "The routine use of psychodynamic formulation . . . [is] a guide to optimal intervention" (p. 566).

Finally, the point is well made that follow-up studies of untreated children and children treated by different methods are lacking. Thus the treatment modality selected in most cases depends more on the subjective bias of the clinician than on hard evidence that the modality selected is the most effective for a particular emotional problem. This being so, it would seem that more stress should have been placed in this report on the need to systematically evaluate the effectiveness of treatment plans so that the data we sorely lack now will be available for future clinicians.

Overall, this report will make worthwhile reading for professionals of all disciplines involved in the care of emotionally disturbed children and their families.

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The Measurement of Intelligence, *by H.J. Eysenck, Ph.D., D.Sc. Baltimore, Md., Williams & Wilkins Co., 1973, 488 pp., $19.00.*

In these days when so much emotion is generated by any discussion of intelligence, it is reassuring as a scientist to read a book whose author claims in the foreword that the main justification for the book is the belief that "facts are essential in coming to reasonable judgments."

Dr. Eysenck's concern in this volume is with the facts generated by the measurement of intelligence, not with their social, ethical, or political implications. These he puts aside for another day. He states that intelligence is not a thing but a concept, a working hypothesis, a model, or a paradigm. Its meaning is derived from the structure and coherence of the data resulting from its measurement. The question posed here is a simple one: Has the working concept of intelligence generated through its measurement any significant body of reliable, valid data to justify its use? The social, economic, ethical, and political value of these data is a matter for later consideration.

To get his answer Eysenck surveys the work on the measurement of intelligence over the last 50 years. He presents his survey by selecting what he considers to be the most important 29 papers from this period and reprinting them in this book. Articles by Spearman, Burt, Thurstone, Thorndike, John Anderson, R.B. Cattell, Jensen, McNemar, Barbara Burkes, and others are organized into nine sections—History and Definition of the Concept, Measurement Problems, Developmental Aspects, Types, Analysis of Performance, two sections on Heredity and Environment, Social Class, and Biological Basis. Each section is preceded by an interpretive introduction by Eysenck.

In the final part of the book, Eysenck concludes that the concept, or paradigm (his preferred term), of intelligence has been a fruitful one embracing many divergent facts, that it is quantitative in nature and open to deduction and testing, and that it is perhaps one of the most productive paradigms for psychology in this century. He states that its essential features are best considered at present as "innate, general, cognitive ability."

This stark statement will infuriate many of the social, ethical, and political polemicists who become enraged at the threat to an egalitarian world of any individual differences in performance. But if one follows Eysenck's argument carefully, remembering that intelligence is not a thing but a working concept open to continual investigation and subsequent alteration, the threat disappears; there is room for environmental influence and for alternative hypotheses.

It is time we forgot semantics and returned to our basic scientific task, the measurement of human behavior. One can only hope that the critics of this book, and there will be many, will be objective in their evaluation and follow Eysenck's example in eschewing social, ethical, and political considerations. These are matters demanding much more intricate experimental designs; final answers are best put aside until hard data of the kind "essential in coming to reasonable conclusions" are available.

Eysenck has done a masterful job. Taken together with Matarazzo's *Wechsler's Measurement and Appraisal of Adult Intelligence* (1), which complements it on the clinical side, *The Measurement of Intelligence* offers an orientation to the measurement of intelligence that should satisfy anyone. The Williams & Wilkins Co. is to be congratulated for publishing both.

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Recent Advances in the Biology of Schizophrenia, *by Thomas A. Ban, M.D. Springfield, Ill., Charles C Thomas, 1973, 105 pp., $12.50.*

Dr. Thomas Ban has again demonstrated his special talents—his keen synthetic mind and his urge to set his thoughts to paper. This monograph was developed from lectures delivered by Dr. Ban at the Arizona State Hospital and at McGill University.

Regrettably, the title does not accurately reflect the contents of the book. Dr. Ban has taken research findings mainly from the 1950s and 1960s to construct an overview focusing on biological factors and theories of the etiology of schizophrenia and their interface with biological treatments—especially psychotropic drugs. Conspicuously missing are some of the challenging findings generated by Meltzer's studies of muscle and muscle enzymes (1, 2).

While I commend Dr. Ban for his efforts in digesting and organizing the material contained in some 200 references, the physician or student wishing to be brought up-to-date in biological psychiatry will need to go beyond this monograph.

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Opiate Addiction: Origins and Treatment, *edited by Seymour Fisher and Alfred M. Freedman. New York, N.Y., Halsted Press (John Wiley & Sons), 1974, 233 pp., no price listed.*

This volume is based on the December 1972 meeting of the American College of Neuropsychopharmacology. It contains a number of review papers by leading American investigators in the field of opiate addiction. The strongest papers are on the biochemical underpinnings of addiction. It is well edited and referenced like a library reference book. It will provide inter-

ested students an entré into many facets of the literature on addiction.

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The Technique and Practice of Intensive Psychotherapy, *by Richard D. Chessick, M.D. New York, N.Y., Jason Aronson, 1974, 369 pp., $12.50.*

This book seems to be aimed primarily at the beginner in psychotherapy in that it skims lightly over a broad range of topics. The reader learns of the pitfalls of a fancy office, especially if it includes a receptionist who loves to chatter and gossip with patients. How the decor and lighting of an office can have an undesirable effect as well as how privacy can be attained without "an expensive soundproofing job" are also proffered as practical tips for the uninitiated.

The entire history of psychiatry, from ancient Hindu texts and Greek prophets through Freud and Bleuler, is reviewed in the first 15 pages of the book. Psychoanalytic theory, deemed the basic science of American psychiatry, is presented in the second chapter from both the individual (Freudian) and the interpersonal (Sullivanian) viewpoints. The value of tranquilizers as adjuvants to the therapeutic process is assayed in four paragraphs, enough to dismiss mood-elevating drugs because they produce side effects and to recommend two minor tranquilizers by trade name while discouraging the use of a third.

Not all of the book is folksy and homiletic, however. One chapter consists of an extensive discussion of Freud's contradictory theories of narcissism, Balint's concept of primary-object love, and the relationship of theory to the psychoanalytic treatment of narcissistic personality disorders. A chapter on metapsychiatry—a term the author claims to have invented—provides an unusually clear description of how destructive, restrictive, and malevolent introjects can be expunged by regression of the ego in the treatment setting.

ROBERT J. CAMPBELL, M.D.
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Review of Child Development Research, vol. 3: Child Development and Social Policy, *edited by Bettye M. Caldwell and Henry N. Ricciuti. Chicago, Ill., University of Chicago Press, 1974, 557 pp., $15.00.*

The editors state the purpose of this volume clearly and succinctly in their introduction:

> This volume represents a plea for keeping open lines of communication between those whose work has relevance for social action and those who generate and institutionalize such action.

Consciousness raising has encouraged a rapprochement among researchers, child care practitioners, and society at large. Three themes recur in many of these chapters, each of which deals with important areas of research and their applications. First, words of caution are iterated concerning the premature application of inconclusive and insufficiently validated research findings. Second, the complexity of human relationships precludes the prevention or remediation of developmental arrests and maladaptive behaviors by simple educational measures or environmental manipulations. Third, intervention and remediation have to be based on a thorough knowledge of developmental milestones, an accurate assessment of the mutual relationships between parent and child, and an appreciation of socioeconomic and cultural realities and differences.

Mary Ainsworth's chapter on the "Development of Infant-Mother Attachment" is a well-written, comprehensive review of studies on the precursors of infant-mother attachment, the critical factors and phases for its successful establishment, and the various noxious effects of mother-child separations during the first years of life. In her summary she draws 11 inferences of great importance for practitioners working with children and mothers.

Leonard Berkowitz' "Control of Aggression" reviews factors likely to promote aggressive behavior and those apt to curb its primitive expression. He states that low tolerance for frustration and a high level of anxiety easily lead to aggressive action. A proper balance between frustration and gratification in a consistent and warm parental climate that provides opportunities for learning nonaggressive responses to frustration is the best safeguard against violence.

Elizabeth Herzog and Cecelia Suda conclude from their review of "Studies on Children in Fatherless Families" that the blanket generalizations made about consequences of the father's absence can probably be rejected and that the impact of the father's absence as a discrete variable in itself cannot be researched successfully.

In "Social Class and Development," Cynthia Deutsch points out the complexity of the concept of socioeconomic status and describes the consequent methodological and conceptual problems encountered in social-class developmental studies. She makes an eloquent plea for more exacting analysis of data and interrelationships and for a focus on the whole environment as it interacts with the organism.

The chapter on "Operant Behavior Modification" by Todd Risby and Donald Baer offers a comprehensive review of the theory of operant conditioning and its technical application for developing, reinforcing, extinguishing, or modifying behavior.

Among several important observations and recommendations in "Effectiveness of Environmental Intervention Programs" by Frances Horowitz and Lucile Paden are that intensive individualized programs for infants and young children are likely to produce the most impressive results and that more structured and educationally oriented preschool intervention programs show strong gains. The authors make a fervent plea that the government consider needs rather than costs in its funding of interventive programs.

In "Programs for Disadvantaged Parents" by Catherine Chilman, several important implications drawn from an excellent survey are summarized, e.g., parent education programs are of limited practicality and effectiveness; basic income maintenance is essential for any program that seeks to deal effectively with disadvantaged parents and children; and no satisfactory standardized instruments to measure change in parental attitudes have been developed.

The chapter on "Adoption" by Edmund Meek and that on "The Child and the Law" by Margaret Rosenheim give both historical information on current philosophies and policies governing adoptive practices and on existing laws dealing with child abuse, parents' rights, and juvenile delinquency.

It is impossible to do justice in this short review to the rich and thoughtful content of this volume. I strongly recommend that it be read by all those who have a vital interest in preventive and rehabilitative services for children and families.

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Successful Aging: A Conference Report, *edited by Eric Pfeiffer, M.D. Durham, N.C., Duke University Center for the Study of Aging and Human Development, 1974, 149 pp., $5.00 (paper).*

This volume represents the papers given at a conference titled "Successful Aging" held at Duke University on June 7–9, 1973. The conference was sponsored by the Older Americans Resources and Services Program of the Duke University Center for the Study of Aging and Human Development. It was supported in part by the Administration on Aging, a social and rehabilitation agency of the U.S. Department of Health, Education, and Welfare.

Most of the papers are brief and do not cover the subjects in depth. They give hints as to how one can age more successfully than by simply leaving matters to chance. Jennie Keith-Ross, an anthropologist, contributes a most interesting paper on successful aging in a retirement residence in France.

Many of the articles are anecdotal in nature and many case histories are presented. This report is recommended for those who wish to know the opinions and experiences of some of today's clinicians and research workers in the ever-expanding field of research on aging.

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Research Advances in Alcohol and Drug Problems, vol. 1, *edited by Robert J. Gibbins, Yedy Israel, Harold Kalant, Robert E. Popham, Wolfgang Schmidt, and Reginald G. Smart. New York, N.Y., John Wiley & Sons, 1974, 374 pp., $22.00.*

The primary goal of this series of annual volumes will be the presentation of evaluative papers on significant topics regarding the drug problem from an interdisciplinary viewpoint, an approach "widely advocated but seldom practiced," according to these editors. This first volume, edited by senior scientific staff members of the prestigious Addiction Research Foundation of Ontario, consists of eight chapters of literature reviews of recent research advances. These cover several disciplines, including biology, chemistry, psychology, epidemiology, and clinical studies.

One chapter, titled "Animal Models for the Study of Drug Abuse," attempts to summarize "the conceptual framework for analyzing the behavior of self-administering drugs." The authors of this article use the concepts derived from studies based largely on operant conditioning and suggest the extrapolation from animal studies to human drug behavior.

Another chapter, "Clinical Pharmacology of Marihuana" by Leo Hollister, offers a general and evaluative review of the latest research on marijuana. Most of the articles comment on pertinent problems connected with investigative efforts and offer corrective suggestions for the future. Several papers mention the commendable purpose of trying to make some coherent sense out of the expanding and overlapping literature about the particular topic covered.

As a clinician, I was quite impressed with George Henry's "Treatment and Rehabilitation of Narcotic Addiction." Dr. Henry covers detoxification, opioid maintenance, the antagonistic drugs, psychosocial approaches (e.g., Synanon), and the results of treatment. He concentrates on the critical aspects of recent developments—exactly what is needed to keep abreast of what is significant in the burgeoning literature. Two statements from this chapter are worth quoting:

> We do not know whether most [treatment methods] are better than no treatment at all. . . . We do not know what happens to drug dependent persons who are not treated or incarcerated.

Another excellent paper, "The Epidemiology of Psychoactive and Hallucinogenic Drug Use," is a descriptive essay that surveys methodological difficulties, morbidity and mortality associated with drug use, and the characteristics of drug users. It also offers some definitive conclusions and research directions.

The entire volume represents high-quality efforts at condensing and clarifying advances in drug research. Although the jacket states, "This book focuses on drug addiction," at least one-third of the book is concerned with alcohol. It should be a good reference volume for anyone searching for the latest material for teaching or research. The bibliographies are extensive—one chapter alone has 540 references. Finally, special mention should be made of the excellent 50-page index that greatly increases the book's usefulness.

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Psychiatric Diagnosis, *by Robert A. Woodruff, Jr., M.D., Donald W. Goodwin, M.D., and Samuel B. Guze, M.D. New York, N.Y., Oxford University Press, 1974, 212 pp., $7.95; $4.95 (paper).*

This well-researched and well-organized book deals in some detail with the various diagnostic entities seen in the clinical practice of psychiatry. In their introduction, the authors point out:

> There are many diagnostic categories in psychiatry, but few are based on a clinical literature where the conditions are defined by explicit criteria and follow-up studies provide a guide to prognosis. Lacking these features, such categories resemble what sociologists call labeling.

Simple labeling is avoided in this book. The authors show the usefulness of diagnosis based on specifically defined criteria in planning treatment and predicting outcome of illness.

Each chapter is divided into several sections, including definition, historical background, epidemiology, clinical picture, natural history, complications, family history, differential diagnosis, and clinical management. Statements are well documented with references to the psychiatric literature, and the bibliography at the end of each chapter is extensive. At the end of the book there are two appendices, one in support of the medical model of psychiatric illness and the other a summary of diagnostic criteria for use in psychiatric research.

PETER M. ZEMAN, M.D.
Hartford, Conn.

Disordered Thought in Schizophrenia, *by Loren J. Chapman and Jean P. Chapman. New York, N.Y., Meredith Corp. (Appleton-Century-Crofts), 1973, 347 pp., $15.00.*

The Chapmans have done an excellent job of presenting and summarizing the leading theories on disordered thought in schizophrenia. They pose a direct challenge to Arieti's *Interpretation of Schizophrenia* (1) in such statements as the following:

> Von Domarus and Arieti erred in that the laws of Aristotelian logic are not the laws of thought and are not even the laws of most reality-oriented adaptive thought. (p. 188)

This book discusses the evidence for a number of theories concerning the nature of schizophrenic thought disorder. Much of the book is devoted to the problem of identification and measurement of cognitive symptoms as a reflection of disordered thought. The Chapmans critically analyze the methodological problems in research regarding the selection of schizophrenic subjects, measurement of disordered thought, and research designs. They report that most of the available research evidence on theories of schizophrenic disorder fail to use the most appropriate design for measuring cognitive deficit of matched tasks in order to delineate the subvarieties of schizophrenic thought disorders.

The authors present the leading theories on disordered thought in schizophrenia carefully and historically, beginning with Bleuler's theory of broken associative threads. They describe the theories of excessive yielding to normal biases, loss of abstract thinking, errors in syllogistic reasoning, and the phenomenon of overinclusion. They also discuss regression to an early stage of development in psychoanalysis, schizophrenic thought disorder as a phase in response to emotional problems, the Shakow formulation of loss due to a major set, defects in attention and information processing, the drive theory, schizophrenic cognition, and theories based on schizomimetic conditions. They emphasize the heterogeneity of schizophrenia as the basic clinical reality of schizophrenic thought disorders.

The authors are trying to clear a field through the jungles of schizophrenic research for further objective study. They have come to three tactical conclusions. These are not startlingly new but will be helpful in redirecting the attention of researchers, clinicians, teachers, and students of schizophrenia to the following efforts: 1) determining the different kinds of thought disorders in schizophrenia, 2) using measures of thought disorder to compare different kinds of schizophrenic patients with one another, and 3) discovering the subgroupings of patients within schizophrenia. (The authors' differential discussion of process and reactive schizophrenia, for instance, is exemplary.)

One other strategic conclusion they come to is that the "investigation of a possible schizophrenic defect in information processing seems promising." I agree with this statement, which points to a very fruitful approach. The apparent schizophrenic verbalizations are but a final common pathway of a manifestation of information distortion that can occur at a genetic cellular biochemical level or as a psychosocial distortion of consciousness and communication.

The literature search and references in this book are extensive, but they fail to include more sophisticated nonclinical models of biochemical, neurophysiological, communicational, or cybernetic system theories, apart from the Broadbent model. The authors remain naturally biased in favor of the clinical psychological approach.

I believe that the Chapmans may be overstating their case when they claim that "investigators can solve the problem if they use appropriate research designs and properly chosen patients." It is quite possible that the solution to the enigma of schizophrenia may come from outside of the clinical research of schizophrenic patients.

The puzzle of schizophrenic thought might remain unsolved if we do not gain further understanding of the neurophysiological process of normal thinking—the interaction of system function and information within the brain. Nevertheless, I recommend this book not only as a good reference for clinical researchers and practitioners but also as a fine textbook for a survey course for psychiatric residents and graduate students studying disordered thought in schizophrenia.

REFERENCE

1. Arieti S: Interpretation of Schizophrenia. New York, Brunner/Mazel, 1955

H.C. TIEN, M.D.
Lansing, Mich.

Camping Therapy: Its Uses in Psychiatry and Rehabilitation, *edited by Thomas Power Lowry, M.D. Springfield, Ill., Charles C Thomas, 1974, 132 pp., $7.75.*

This collection of 18 articles describes camping programs for normal as well as emotionally and physically disordered children and adults. Each chapter is brief; many contain short case reports.

Providing mental health care in more natural environments to promote integrity and growth has been a relatively neglected subject in psychiatry. Yet the pressures of technological society and its dehumanizing institutions cause many emotional casualties. This strongly suggests rich therapeutic possibilities in camping and its more basic lifestyle.

This book reflects the infancy of camping therapy. It is a brief introduction to its practice and possibilities. The few references to the literature are, for the most part, dated. Several chapters are redundant, and the issue of reentry from the less structured camp setting back into the pressures of civilization (1) is essentially neglected. Camping therapy is clearly fun for patient and staff alike; however, controlled studies and follow-up data are needed to evaluate whether it is effective, how costly it is in relation to its benefits, and what types of patients respond favorably to it.

REFERENCE

1. Muller DJ: Post-camping depression: a lethal possibility. Am J Psychiatry 128:109–111, 1971

DAVID J. MULLER, M.D.
Denver, Colo.

Rorschach Responses in Old Age, *revised ed., by Louise Bates Ames, Ph.D., Ruth W. Métraux, M.A., Janet Learned Rodell, Ph.D., and Richard N. Walker, Ph.D. New York, N.Y., Brunner/Mazel, 1973, 211 pp., $12.50.*

This is a revised edition of the volume of the same name originally published in 1953. The changes between editions consist of the insertion of a page and a half of material on scoring whole responses, an increase from 8 to 61 in the number of persons retested, the deletion of several individual case examples to make room for a new short chapter on supplementary tests, and the addition of 10 new citations to the references.

Of the 200 aged persons whose tests form the basic data in this book, 140 were women. Most of the sample were well educated, of upper- and upper-middle-class socioeconomic status, and between 70 and 100 years old. The Rorschach test was administered in the same way these researchers have given it to children (1). The cards were shown only once and inquiries were gathered immediately following a response.

On the basis of scores approximating those expected of normal younger adults and in the absence of certain qualitative

signs, the authors classed 20 percent of the records as normal, 70 percent as presenile, and 10 percent as senile. Because of the authors' thesis that old age is "reverse growth," they were surprised that such a large percentage of their subjects could be classed as normal on the basis of their Rorschach performance. However, it seems to me and to others who have studied aged persons in the 20 years since the first edition of this volume appeared that the presenile group merit the most attention.

Both the number of persons classified in this book as presenile and the descriptions of their performance suggest that subgroups exist within this larger group. Two of the features attributed to presenile individuals—garrulousness and repetitiveness—have been noted by other researchers. In this book Ames and associates give vivid descriptions of the transactional impact that presenile behavior has on others.

The weaknesses of the book lie in its oversimplification of old age as a period of reverse growth and its efforts to locate individual aged persons at a single behavior level or level of intactness rather than using such concepts as dimensions or domains of behavior. The latter permit reference to complex interactions among traits, skills, functions, and decrements.

The authors' findings are far more complex and fascinating than their concepts of levels. The merits of the book lie in the qualitative sign checklists devised by the authors. One list of signs consists of those found in childrens' Rorschachs that do not appear in Rorschachs of normal adults. A second list of signs is composed of those which the writers feel do not characteristically appear in either normal adults' or normal childrens' records. These checklists become central in ordering the findings of this research.

In summary, one can recommend the sign checklists devised by the authors to quantify the qualitative features of Rorschach performance in aged persons without endorsing some of the theoretical underpinnings of the volume. This book had much to offer when it first appeared 20 years ago and still does.

REFERENCE

1. Ames LB, Learned J, Metraux RW, et al: Child Rorschach Responses, rev ed. New York, Brunner/Mazel, 1973

MARGARET THALER SINGER, PH.D.
Berkeley, Calif.

Basic Concepts of Psychoanalytic Psychiatry, *by Elizabeth R. Zetzel, M.D., and W.W. Meissner, M.D. New York, N.Y., Basic Books, 1973, 305 pp., $10.00.*

Dr. Zetzel was engaged in collaborating on this book at the time of her sudden death in November 1970. Dr. Meissner had undertaken the task of rewriting, revising, and expanding lectures that Dr. Zetzel had presented in a series of seminars and public lectures in Boston over a span of several years to present a coherent and integrated account of the psychoanalytic perspective. As the draft of each chapter was finished, Dr. Zetzel read and commented on possible changes. This process had been completed for the first 13 chapters at the time of her death. She had the final 3 chapters in hand and had made some comments about them to Dr. Meissner, but she had not reviewed them as completely as she had the others.

Drs. Zetzel and Meissner define the basic structure of this book as an account of the developmental process, including its inherent potentialities for progressive adaptation and regressive retrenchment. There is an integration of the dynamic, economic, structural, and adaptational points of view in this setting.

This volume might be viewed as a beginning textbook in psychoanalytic psychiatry for psychiatric residents and allied personnel. It is a courageous attempt to weld together the various phases of Freudian psychoanalytic theory, more recent developments in ego psychology, the concepts of interpersonal theory and adaptational psychoanalysis, and some of the clinical observations in child development as well as in sleep and dream research.

Such integration is a difficult task; no great measure of success is seen in these pages. Most of the material is devoted to tracing Freudian theory chronologically through the energic and structural contexts. The authors note that Freud heralded the importance of adaptation on many occasions. Chapter after chapter is devoted to Freudian theory; they cover anxiety, repression, and their interaction, primary and secondary process, and the developmental hypothesis, to name a few.

The greatest number of references in the short bibliography (71 entries), after Freud, are to Erikson and David Rapaport. Hartmann and Kris are mentioned once. There are a number of references to contributions by various workers in the text that are not included in the bibliography, e.g., Kris's regression in the service of the ego and the sleep research of Aserinsky and Kleitman. In the latter context, neither Fisher nor Dement is even mentioned. There is also no allusion to Sandor Rado in the discussion of adaptational psychoanalysis.

My impression is that the authors were torn between pursuing their goal of a coherent and comprehensive account of psychoanalytic psychiatry and becoming liable to charges of apostasy in psychoanalytic thinking. Some of the writing is heavy and obscure—much less clear than the good translations of Freud and never approaching the style and conciseness of Erikson.

Although the final three chapters were not fully reviewed by Dr. Zetzel, she approved their inclusion in principle. Each of the chapters, titled "Neurotic Development and Analyzability," "An Approach to the Borderline Patient," and "Psychoanalysis As Therapy," presents a fitting topic for another volume. However, each is necessarily given only superficial treatment and could be a source of confusion to the young psychiatrist.

JAMES P. CATTELL, M.D.
New York, N.Y.

The Depressed Woman: A Study of Social Relationships, *by Myrna M. Weissman and Eugene S. Paykel. Chicago, Ill., University of Chicago Press, 1974, 279 pp., $10.00.*

This book describes an exploratory study in which 40 women with acute depression but with no physical illness or psychosis were compared with 40 women who were considered normal, i.e., free from psychiatric and physical illness. The two groups were matched as to age, religion, ethnic origin, and neighborhood. The social relations and symptomatology of both groups were studied at regular intervals over a 20-month period in the clinics of Yale University and Tufts University.

Treatment for the depressed women included the use of an antidepressant (amitriptyline) as well as psychotherapy and counseling. Interview and questionnaire techniques were used in addition to the standard clinical interview. Six aspects of the subjects' behavior were rated: behavior and performance at work, during leisure time, in the extended family, in the marital role, in the parental role, and in the family unit. Factor analysis and correction for reliability and validity were carried out.

The results of this study clarify many of the conflicting ideas about depressed women that have been reported. This study

found that although these depressed women were moderately impaired in their daily lives and interpersonal relationships, their marital relationships became the arena for the depression. Friction, poor communication, dependency, and diminished sexual satisfaction were evident. Acutely depressed women showed an increase in hostility, especially toward their husbands and children. Remission of symptoms and improvement in social adjustment were more rapid during the first 2 months of the 20-month treatment period.

The normal subjects, by comparison, were well adjusted and experienced housework as satisfying, parent-child relations as warm and involved, and marriage as affectionate and harmonious.

The authors of this book are to be congratulated for their clear presentation of this carefully controlled research study. This work should serve as a reliable frame of reference for further research, not only of depression, but also of normal subjects. This book should be of real value to all those who are involved in the day-to-day care of depressed women.

HELEN B. CARLSON, M.D.
Downey, Ill.

Electroencephalography (EEG) of Human Sleep: Clinical Applications, *by Robert L. Williams, M.D., Ismet Karacan, M.D., D.Sc., and Carolyn J. Hursch, Ph.D. New York, N.Y., John Wiley & Sons, 1974, 164 pp., $15.00.*

This book is a summary of about a decade of intensive work at the sleep laboratories of the University of Florida. The data represent over 6,000 all-night sleep EEGs on hundreds of normal subjects aged 3 to 80 who slept in the laboratory on successive nights. The purpose of the work was to develop an electrographic (EEG and eye-movement) atlas of normal sleep. The reader is given a variably adequate account of the laboratory procedures and equipment, which is critical for an understanding of the resultant tracings.

The extensive bibliographies at the end of each chapter identify supplemental reading. In the foreword, Dement likens the data on sleep recorded in this book to the familiar height-and-weight growth charts. He states that the data add a new dimension to the assessment of normal development.

Sleep EEGs are recorded at a chart speed of 15 mm/second, which results in 1,000 or more pages a night for each patient. Some sort of data reduction is imperative, so the records are scored by one-minute epochs. This yields hundreds of scores for each night of sleep. Fortunately, it has been known since the 1930s that there is a more or less steady progression through the various stages of sleep. This permits classification of large blocks of time into pattern stages. Sleep researchers have achieved a moderate consensus about the criteria for stages 1 through 4 and for the REM stage.

There is less agreement regarding number and placement of electrodes. This book, although written by researchers at one laboratory, shows a variability that complicates the understanding of illustrative sleep stages. There is also a puzzling tendency for recorded eye movements to be of variable phase and of higher voltage on the left side.

This atlas is meant to be useful to a wide range of professionals, who need a clear display of the electrographic features of the sleep stages that would constitute a standard against which their own material could be rated. Such pattern recognition is very substantially handicapped when the figures showing the data are printed at a reduced scale. Indeed, two different scale reductions are used in this book, and the degree of reduction is not really precisely stated for either. The elimination of redundant labels and wasted white space in this book could have resulted in slightly shorter time samples that could have been displayed life-sized and therefore been much more useful to the reader wishing to adopt this classification system. To the degree that such illustrations are important, as they are in EEG, book size would better be adapted to figures than to text.

The main and unique contribution of this work is contained in a long sequence of admirably clear tables and figures. From these one can determine time in bed, time from onset of sleep to final awakening as well as the percentage of this time spent in actual sleep, sleep onset latency, a sleep efficiency index, the proportion of time spent in each stage of sleep, and the duration of each such sleep stage. The tables and figures also show the appropriate statistical handling of this mass of data. Further, each of these categories is detailed by age groups, which are further contrasted as to sex. (The latter differences are largely nonsignificant.) The illustrative material is ingeniously plotted and easy to understand. The REM phenomena receive explicit treatment.

How is the clinician to use this information in the diagnosis and treatment of the patient with a sleep disorder? One chapter of the book is devoted to the dyssomnias, which, together with headache, must comprise man's most benignly annoying discomforts. The enthusiasm of the authors for all-night sleep studies is not substantiated by present applications to most of the dyssomnias, however. There are some specific exceptions (epilepsy, narcolepsy, Kleine-Levin syndrome, and Pickwickian syndrome) where sleep EEG is indeed useful, although all-night sleep study is rarely required.

The concluding chapter on future directions touches on the likelihood that biochemical variables will be important in sleep research. Stage 2 sleep, which makes up half of our sleep throughout life, also needs investigation. No doubt jet lag will be studied; it may be necessary then to record in homes, hotels, and airports. Also to be studied is the overwhelming drowsiness that occurs while one is sitting upright in a lecture hall. The authors recognize the fact that for these and other problems much help will be needed from computers.

My final regret about this book is given with the hope that authors, editors, and publishers may yet mend their ways and present material so it is maximally easy to read and understand. I refer to the problem of reference citation within text. In this volume, references are identified by names and year, generally with the inclusion of all (up to six) authors and only occasional use of a welcome "et al." The use of the latter is not related to the number of authors. Since much sleep research appears under multiple authorship, and since many of the names are double- and even triple-hyphenated, the reader must scan through a veritable thicket of names and numbers to reach the text. There is a better way, and the resultant savings in cost and paper could be contributed to improved display of the primary electrographic data.

CHARLES E. HENRY, PH.D.
Cleveland, Ohio

The Administration of Mental Health Services, *edited by Saul Feldman, D.P.A. Springfield, Ill., Charles C Thomas, 1973, 383 pp., $18.75.*

The editor of this book attempts to compile the thinking of a number of persons whose expertise in the generic aspects of administration and whose specific knowledge of the mental health

field qualify them to adapt the principles of general administration to the field of mental health.

The primary point of the book is that administration in the mental health field is so modified by the environment in which it is applied that it is a specialized and individualized field of its own. In my opinion, inadequate emphasis is given to the fact that the principles of sound administration are generalizable; it is merely the technique of application of these principles that requires modification.

The book states that mental health professionals, by training and by nature, fight the restriction and systematization of a strong administrative organization. While discipline within their practices may be well established, their lack of discipline in regard to established administrative procedures makes them a difficult group with which to cope.

The book focuses on the field of government-funded mental health programs; little or no attention is paid to the private and proprietary areas of mental health. The various authors discuss the tremendous growth in size and complexity that has occurred in the mental health field and point out the obvious gap that develops when administrative procedures such as budgeting, personnel management, financing, and management information do not catch up. However, they do not offer many solutions except to say that the overall field of mental health administration needs more emphasis.

This book could serve as a sourcebook for readings in the area of mental health administration, but it is not the basic text that the jacket suggests it to be.

EDWARD S. FLEMING, M.D.
Washington, D.C.

Submission of New Research Abstracts for the 1975 Annual Meeting, May 5–9, Anaheim, California

The 1975 annual meeting will again include a series of two New Research sessions. Those interested in presenting papers at these sessions should obtain an abstract form from the Office of the Chairman of the Program Committee, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. It is not necessary to supply the full text of a paper submitted for consideration for New Research sessions. Completed abstracts must be received in the Office of the Chairman of the Program Committee by March 1, 1975.

This Month's Reviewers

FELIX F. LOEB, JR., M.D., is Assistant Clinical Professor of Psychiatry, University of California, San Diego, Calif.

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EDWARD S. FLEMING, M.D., is President, Psychiatric Institutes of America, Washington, D.C.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

Marital and Sexual Counseling in Medical Practice, *2nd ed., edited by D. Wilfred Abse, M.D., Ethel M. Nash, M.A., and Lois M.R. Louden, Ph.D. New York, N.Y., Harper & Row, 1974, 558 pp., $14.95.*

The Healing Community: Dynamics of the Therapeutic Milieu, *by Richard Almond. New York, N.Y., Jason Aronson, 1974, 406 pp., $17.50.*

Mental Retardation: Nature, Cause, and Management, *by George S. Baroff. Washington, D.C., Hemisphere Publishing Corp. (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 475 pp., $17.95.*

Research Strategies in Psychotherapy, *by Edward S. Bordin. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 258 pp., $16.95.*

Neurology of Infancy and Childhood, *edited by Sidney Carter, M.D., and Arnold P. Gold, M.D. New York, N.Y., Appleton-Century-Crofts (Prentice-Hall), 1974, 195 pp., no price listed.*

Irony in the Mind's Life: Essays on Novels by James Agee, Elizabeth Bowen, and George Eliot, *by Robert Coles. Charlottesville, Va., University Press of Virginia, 1974, 204 pp., $9.75.*

Administrative Techniques of Rehabilitation Facility Operations, *edited by John G. Cull, Ph.D., and Richard E. Hardy, Ed.D. Springfield, Ill., Charles C Thomas, 1974, 272 pp., $15.75.*

Organization and Administration of Drug Abuse Treatment Programs: National and International, *edited by John G. Cull, Ph.D., and Richard E. Hardy, Ed.D. Springfield, Ill., Charles C Thomas, 1974, 335 pp., no price listed.*

Experimental Behaviour: A Basis for the Study of Mental Disturbance, *edited by John H. Cullen. New York, N.Y., Halsted Press (John Wiley & Sons), 1974, 440 pp., $24.50.*

Manuel de Psychiatrie de l'Enfant, *2nd ed., by J. de Ajuriaguerra. Paris, France, Masson et Cie, 1974, 1,066 pp., 195 French francs.*

The Cultural Drama: Modern Identities and Social Ferment, *edited by Wilton S. Dillon. Washington, D.C., Smithsonian Institution Press 1974, 328 pp., $17.50.*

Manuel de Psychiatrie, *4th ed., by Henri Ey, P. Bernard, and Ch. Brisset. Paris, France, Masson et Cie, 1974, 1,212 pp., 160 French francs.*

Divorce: The New Freedom. A Guide to Divorcing and Divorce Counseling, *by Esther Oshiver Fisher, LL.B., Ed.D. New York, N.Y., Harper & Row, 1974, 198 pp., $7.95.*

The Psychoanalysis of War, *by Franco Fornari, translated by Alenka Pfeifer. Garden City, N.Y., Anchor Books (Anchor Press/Doubleday), 1974, 270 pp., $2.95 (paper).*

Sex Differences in Behavior, *edited by Richard C. Friedman, M.D., Ralph M. Richart, M.D., and Raymond L. Vande Wiele, M.D. New York, N.Y., John Wiley & Sons, 1974, 488 pp., $25.00.*

The Psychoanalysis of Dreams, *by Ángel Garma. New York, N.Y., Jason Aronson, 1974, 220 pp., $10.00.*

Stigma: Notes on the Management of Spoiled Identity, *by Erving Goffman. New York, N.Y., Jason Aronson, 1974, 147 pp., $7.50.*

A Guide to Psychiatric Diagnosis and Understanding for the Helping Professions, *by Martin Goldberg, M.D. Totowa, N.J., Littlefield, Adams & Co., 1974, 176 pp., $2.95 (paper).*

Research on Methods and Programs of Drug Education. International Symposia on Alcohol and Drug Addiction 3, *edited by Michael Goodstadt. Toronto, Canada, Addiction Research Foundation of Ontario, 1974, 187 pp., $6.25 (paper).*

The Silent Misery—Why Marriages Fail, *by Gerald G. Griffin, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 280 pp., $10.75; $6.95 (paper).*

Minimal Brain Dysfunction, *by Mortimer D. Gross, M.D., and William C. Wilson, M.D. New York, N.Y., Brunner/Mazel, 1974, 202 pp., $10.95.*

Techniques and Approaches in Marital and Family Counseling, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 210 pp., no price listed.*

Madness Network News Reader, *edited by Sherry Hirsch, Joe Kennedy Adams, Leonard Roy Frank, Wade Hudson, Richard Keene, Gail Krawitz-Keene, David Richman, and Robert Roth. San Francisco, Calif., Glide Publications, 1974, 192 pp., $5.95 (paper).*

Clinical Prediction in Psychotherapy, *by Leonard Horowitz. New York, N.Y., Jason Aronson, 1974, 365 pp., $15.00.*

World History of Psychiatry, *edited by John G. Howells, M.D., D.P.M. New York, N.Y., Brunner/Mazel, 1975, 728 pp., $25.00.*

Psychiatric Disorders in Adolescents, *by Richard W. Hudgens, M.D. Baltimore, Md., Williams & Wilkins Co., 1974, 228 pp., $15.50.*

The Limbic System, *by Robert L. Isaacson. New York, N.Y., Plenum Press, 1974, 279 pp., $14.95.*

The Psychology of Superstition, *by Gustav Jahoda. New York, N.Y., Jason Aronson, 1974, 147 pp., $7.50.*

The Treatment of Alcoholism: Theory, Practice, and Evaluation, *by E.J. Larkin, Ph.D. Toronto, Canada, Addiction Research Foundation of Ontario, 1974, 68 pp., $2.95 (paper).*

Shame and Guilt in Neurosis, *by Helen B. Lewis, Ph.D. New York, N.Y., International Universities Press, 1974, 525 pp., $4.95 (paper).*

Troubled Children: Their Families, Schools and Treatments, *by Leonore R. Love and Jaques W. Kaswan, with Daphne Blunt Bugental. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 302 pp., $17.95.*

Cognition and Behavior Modification, *by Michael J. Mahoney. Cambridge, Mass., Balinger Publishing Co. (J.B. Lippincott Co.), 1974, 337 pp., no price listed.*

Advances in Psychobiology, vol. 2, *edited by Grant Newton and Austin H. Riesen. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 312 pp., $24.95.*

Assessing Minority Group Children: A Special Issue of *Journal of School Psychology*, *edited by Dr. Beeman N. Phillips. New York, N.Y., Behavioral Publications, 1973, 108 pp. no price listed.*

René: The Biography of a Schizophrenic, *by Elizabeth Plante, R.N. New York, N.Y., Vantage Press, 1974, 37 pp., $4.50.*

The Practical Management of Head Injuries, *3rd ed., by John M. Potter, M.A., D.M. Chicago, Ill., Year Book Medical Publishers, 1974, 91 pp., $7.95 (paper).*

Learning Sex Roles: American and Scandinavian Contrasts, *by Joseph E. Ribal. San Francisco, Calif., Canfield Press (Harper & Row), 1973, 266 pp., $4.95 (paper).*

Early Child Care in the United States of America. International Monograph Series on Early Child Care 3, *by Halbert B. Robinson, Nancy M. Robinson, Martin Wolins, Urie Bronfenbrenner, and Julius B. Richmond. New York, N.Y., Gordon and Breach, 1973, 224 pp., $14.50.*

How Behavior Means, *by Albert E. Scheflen, M.D. New York, N.Y., Jason Aronson, 1974, 208 pp., $12.50.*

Proceedings, 7th International Conference for Suicide Prevention, *edited by Nico Speyer, M.D., Rene F.W. Diekstra, Ph.D., and Karel J.M. van de Loo, Ph.D. Amsterdam, The Netherlands, Swets & Zeitlinger, 1974, 642 pp., no price listed.*

Perspectives on Human Sexuality: Psychological, Social and Cultural Research Findings, *edited by Nathaniel N. Wagner. New York, N.Y., Behavioral Publications, 1974, 508 pp., no price listed.*

Eminent Contributions to Psychology, vol. 1: A Bibliography of Primary References, *edited by Robert I. Watson, Sr. New York, N.Y., Springer Publishing Co., 1974, 470 pp., $24.00.*

Psychoactive Drugs, Including Combinations. Data Processing in Medicine, vol. 3, *by François Wider. New York, N.Y., S. Karger, 1974, 264 pp., $44.00.*

Narcotics and the Hypothalamus. Kroc Foundation Symposia 2, *edited by Emery Zimmermann and Robert George. New York, N.Y., Raven Press, 1974, 266 pp., $18.95.*

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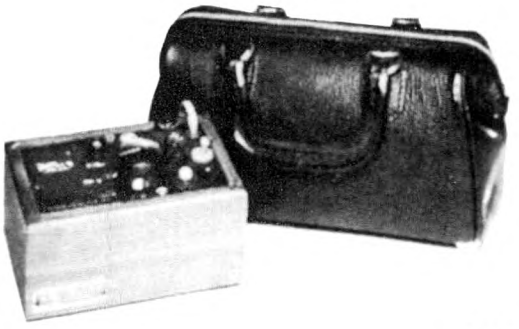
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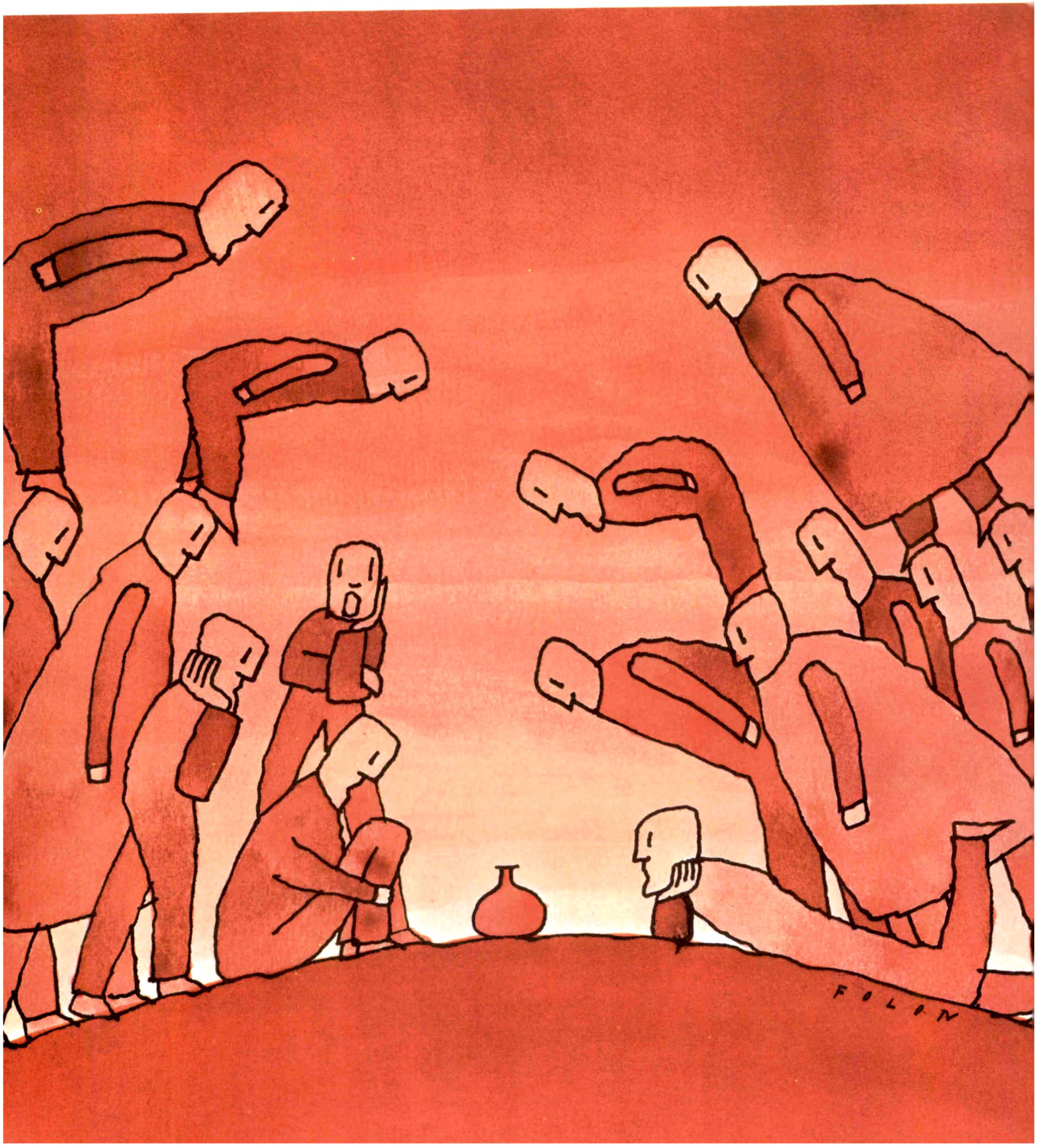
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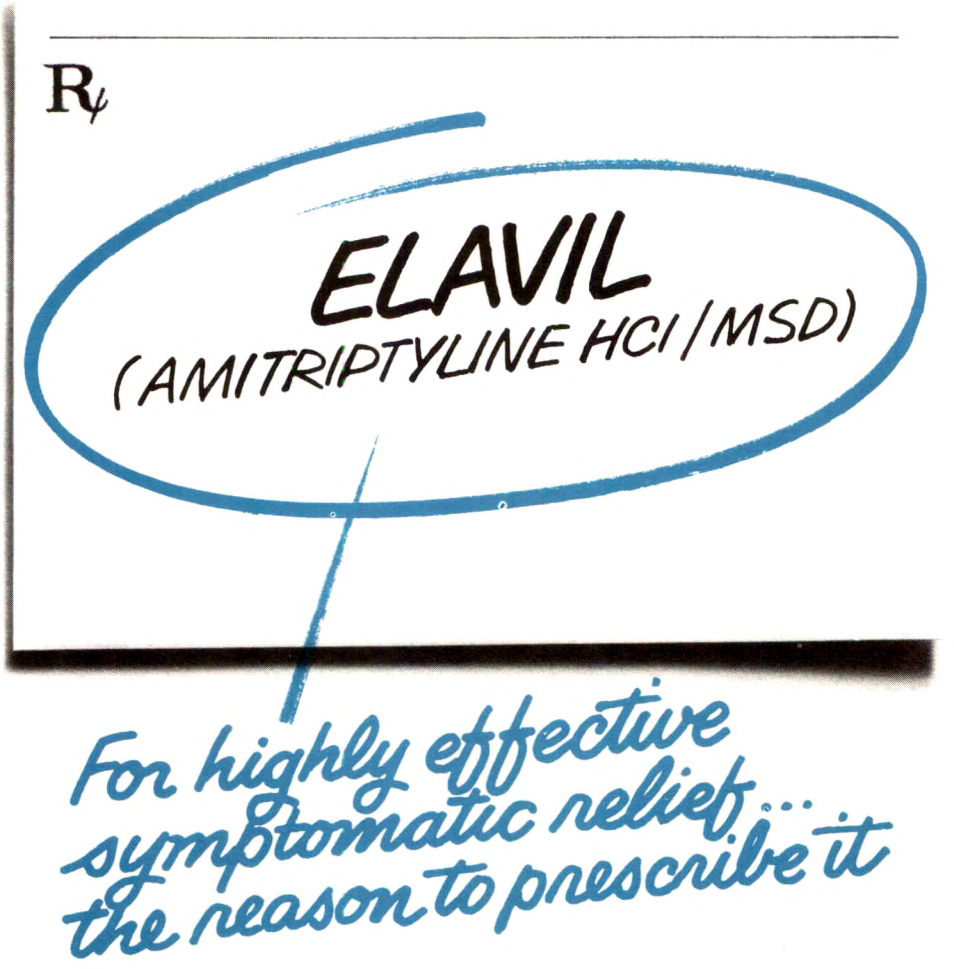
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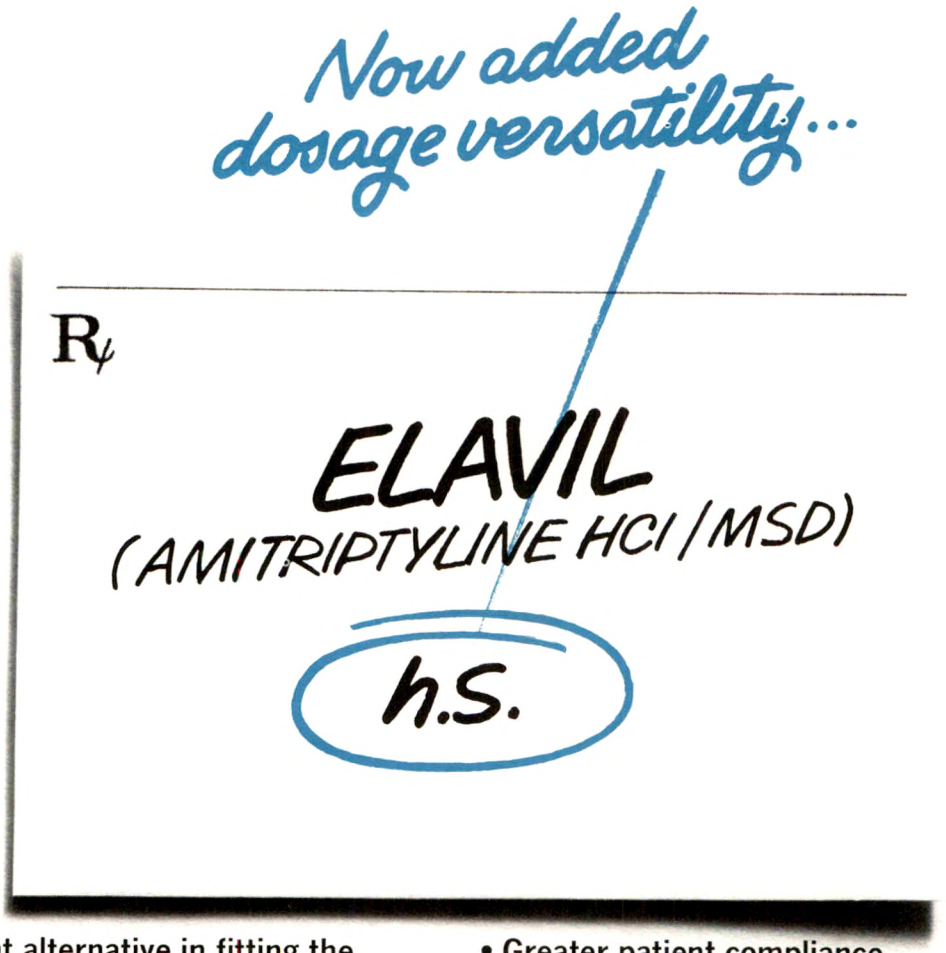


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In the treatment of clinically significant depression...





- **An important alternative in fitting the medication to the patient's needs**

  Once-a-day dosage at bedtime is an appropriate way to start—and maintain—many patients on therapy. Of course, ELAVIL may be administered two, three, or four times as well as once a day. This dosage versatility allows prescribing precisely for the patient's needs.

- **Once-a-day dosage schedule for adult outpatients**

  Therapy should be initiated with 50 mg to 100 mg at bedtime. This may be increased by 25 or 50 mg added to the bedtime dose as necessary to a maximum daily dose of 150 mg. The usual maintenance dose is 50 to 100 mg a day given at bedtime, though in some patients, 40 mg per day is sufficient.

- **Greater patient compliance**

  The simplicity of once-a-day dosage at bedtime makes it easier for patients to adhere to a regimen—an especially important consideration in depressed patients whose self-motivation may be at a low ebb.

  Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

once a day at bedtime

Please see addendum on following page for other details of dosage and administration including divided daily doses, dosage in hospitalized patients, and dosage in elderly and adolescent patients.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

added dosage versatility in clinically significant depression

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



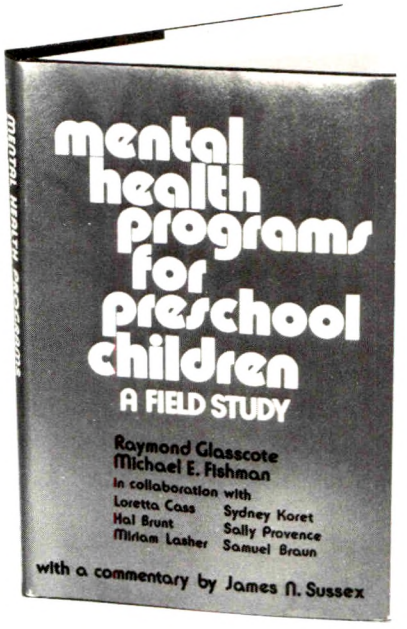
For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

A Timely New Book from The Joint Information Service

This latest Joint Information Service field study provides a concise, comprehensive overview of the complex matter of the very young American child and his mental health, and then describes in intimate detail seven unique programs for pre-school children with problems—from North Hollywood's Dubnoff Center, emphasizing education as its primary therapeutic modality, to Baltimore's Martin Luther King, Jr. Parent-Child Center, serving two housing projects, served by Johns Hopkins, and largely governed by its own people. All different in treatment approach and philosophy, the programs described are uniform in their dedication to innovation in improving service to the emotionally disturbed very young child, and, equally, to the emotional well being of all young children.

This thoughtful and perceptive description of what has been created by some of the best informed, most experienced and thoughtful specialists in mental health services for very young children should be welcome to all involved in the mental health of children and a casebook for those dealing with child and family mental health.



An articulate exposition of the immense problems and encouraging accomplishments in a particularly difficult area of endeavor . . . . Beyond their concern with the manifestly ill child, the authors intriguingly explore what may be needed to enhance the mental good health of all young children . . . . A significant contribution.

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President, American Association of Psychiatric Services for Children

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Basic considerations in the management of insomnia...

Prescribe sleep medication at the lowest effective dose...

When you determine that sleep medication is indicated for a patient with insomnia, individualize dosage. In some cases, especially in mild insomnia or elderly or debilitated patients, lower than usual dosage may effectively relieve symptoms. As patient contact is maintained during treatment, dosage can later be titrated according to individual response.

Treat pharmacologically only as long as necessary...

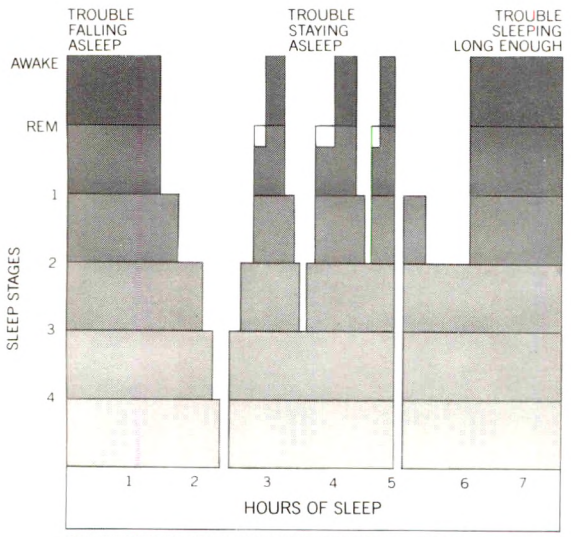
Sleep medication should usually be considered a limited course of treatment. Whether insomnia is transient or chronic, chemotherapy should end as soon as possible. In this light, the number of prescription refills should depend on your evaluation of the patient.

Select an agent known to be relatively safe, and effective for the presenting type of insomnia...

Dalmane (flurazepam HCl) is useful for the three most common types of insomnia (see composite sleep profile). On average, Dalmane provides sleep within 17 minutes that lasts 7 to 8 hours with few nighttime awakenings.[1-4] Also, Dalmane 30 mg (the usual adult dosage) has been shown consistently effective during 14 consecutive nights of administration without increasing dosage.[5]

Dalmane is relatively safe and generally well tolerated; morning "hang-over" is infrequent. In the elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness or ataxia.





COMPOSITE PROFILE OF THREE COMMON TYPES OF INSOMNIA

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



References:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
3. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970

A basic consideration when sleep medication is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.



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By helping to reduce the frequency and intensity of psychotic symptoms, Navane (thiothixene) often permits resumption of more normal, more productive living.

The antipsychotic effectiveness of Navane—with relatively little drowsiness—helps patients remain more active, more alert, better able to meet the ordinary demands of life.

Cardiovascular side effects such as hypotension and nonspecific EKG changes are relatively rare with Navane (thiothixene). Extrapyramidal symptoms have been reported, but are usually controlled by reduction in dosage and/or administration of antiparkinson drugs.

Once you've controlled acute psychosis or psychotic depression, some patients can be maintained on a simple once-a-day dose. This once-a-day regimen can reduce the risk of missed doses with no loss of efficacy.

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Navane®

(thiothixene) (thiothixene hydrochloride)

Capsules 1 mg., 2 mg., 5 mg., 10 mg., 20 mg./Concentrate 5 mg./cc.

Once-a-day–to help control symptoms of psychosis

For prescribing information, including adverse reactions and contraindications please see following page of this advertisement.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg., 2 mg., 5 mg., 10 mg., 20 mg. **Concentrate: 5 mg./cc.** **Intramuscular: 2 mg./cc.**

PRESCRIBING INFORMATION
Navane® (thiothixene)
Capsules 1 mg., 2 mg., 5 mg., 10 mg., 20 mg. (thiothixene hydrochloride)
Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane (thiothixene), there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg./kg./day), rabbits (3 to 50 mg./kg./day), and monkeys (1 to 3 mg./kg./day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS-depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane (thiothixene) may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane [thiothixene] for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis), have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration – As with all intramuscular preparations, Navane (thiothixene hydrochloride) Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the midlateral thigh.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower- and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following reactions have been reported with Navane. However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane (thiothixene) is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur, although it usually subsides with continuation of Navane therapy. The incidence of sedation appears to be similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudoparkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: Although not reported with Navane, certain antipsychotic agents have been associated with persistent dyskinesias. Tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leucocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration because safe conditions for its use have not been established.

Dosage and Administration. Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Usage in children under 12 years of age is not recommended.

Navane Intramuscular Solution—For Intramuscular Use Only. Where more rapid control and treatment of behavior is desirable, the intramuscular form of Navane (thiothixene hydrochloride) may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg. of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg./day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg. three times daily. If indicated, a subsequent increase to 15 mg./day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg. twice daily.

The usual optimal dose is 20 to 30 mg. daily. If indicated, an increase to 60 mg./day total daily dose is often effective. Exceeding a total daily dose of 60 mg. rarely increases the beneficial response.

Some patients have been successfully maintained on once-a-day Navane (thiothixene) therapy.

Overdosage. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, disturbances of gait, or coma.

Treatment: Essentially symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Picrotoxin or pentylenetetrazol should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is available as capsules containing 1 mg., 2 mg., 5 mg., and 10 mg. in bottles of 100 and 1,000. Navane is also available as capsules containing 20 mg. of thiothixene, in bottles of 100 and 500.

Navane (thiothixene hydrochloride) Concentrate is available in 120 cc. (4 oz.) bottles with an accompanying dropper calibrated at 2 mg., 4 mg., 5 mg., 6 mg., 8 mg. and 10 mg. Each cc. contains thiothixene hydrochloride equivalent to 5 mg. of thiothixene. Contains alcohol, U.S.P. 7.0% v/v. (small loss unavoidable).

Navane (thiothixene hydrochloride) Intramuscular Solution is available in a 2 cc. amber glass vial in packages of 10. Each cc. contains thiothixene hydrochloride equivalent to 2 mg. of thiothixene, dextrose 5% w/v, benzyl alcohol 0.9% w/v.

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New APA Task Force Reports

Behavior Therapy in Psychiatry

This comprehensive report reviews the historical development of behavior therapy, its efficacy for the treatment of psychiatric problems, its current forms and uses as well as potential abuses, and its relationship to dynamic psychiatry. Approved for publication by the APA Council on Research and Development, the Report was prepared by a Task Force comprising Lee Birk, M.D., John Paul Brady, M.D., Alan J. Rosenthal, M.D., W. Douglas Skelton, M.D., Joseph B. Stevens, M.D., and Consultants Stephanie B. Stolz, Ph.D., Joseph V. Brady, Ph.D., Arnold A. Lazarus, Ph.D., James J. Lynch, Ph.D., and Edwin J. Thomas, Ph.D.

Report No. 5 — 75 pages, June 1973 — Single copy $3.50

Patterns of Private Psychiatric Practice

The Present and Future Importance of Patterns of Private Psychiatric Practice in the Delivery of Mental Health Services

This report marks the first formal statement the Association has ever issued delineating the vital role of its private practitioner members in the delivery of mental health services in the U.S. Contains sections on patterns of private practice, the economics of it, the impact of third party payments on it, its relation to the public sector, and an assessment of the overall contribution of the private sector to the treatment of mental illness. Stresses the theme that any national system for the delivery of mental health services must be a "balanced mix" of both the private and public sectors, each reinforcing the other. Approved for publication by the Council on Mental Health Services, the Report was prepared by a Task Force comprising Drs. Ewald Busse, Rogers J. Smith, Reed S. Andrus, Winston Cochran, Albert A. Lorenz, Robert L. Leopold, Louis W. Nie, and Consultants Alan I. Levenson, Zigmond M. Lebensohn, Walter E. Barton, and Mr. Robert L. Robinson.

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Megavitamin and Orthomolecular Therapy in Psychiatry

This comprehensive report reviews and evaluates claims for the effectiveness of the megavitamin rationale, clinical trials of NA and NAA with criticisms and attempts at replication, early clinical trials and attempts at replication, pellagra, schizophrenia and the question of NAD, the diagnosis of schizophrenia, patient selection, and specific phase-treatment programs of orthomolecular psychiatrists, quantitative aspects of megavitamin therapy, incompatibility of Methyl-receptor and NAD positions, and toxicity. Published with the approval of the Council on Research and Development, the Report was prepared by a Task Force comprising Drs. Morris Lipton, Thomas A. Ban, Francis J. Kane, Jerome Levine, and Consultant Richard Wittenborn, Ph.D.

Report No. 7 — 54 pages, June 1973 — Single copy $3.00

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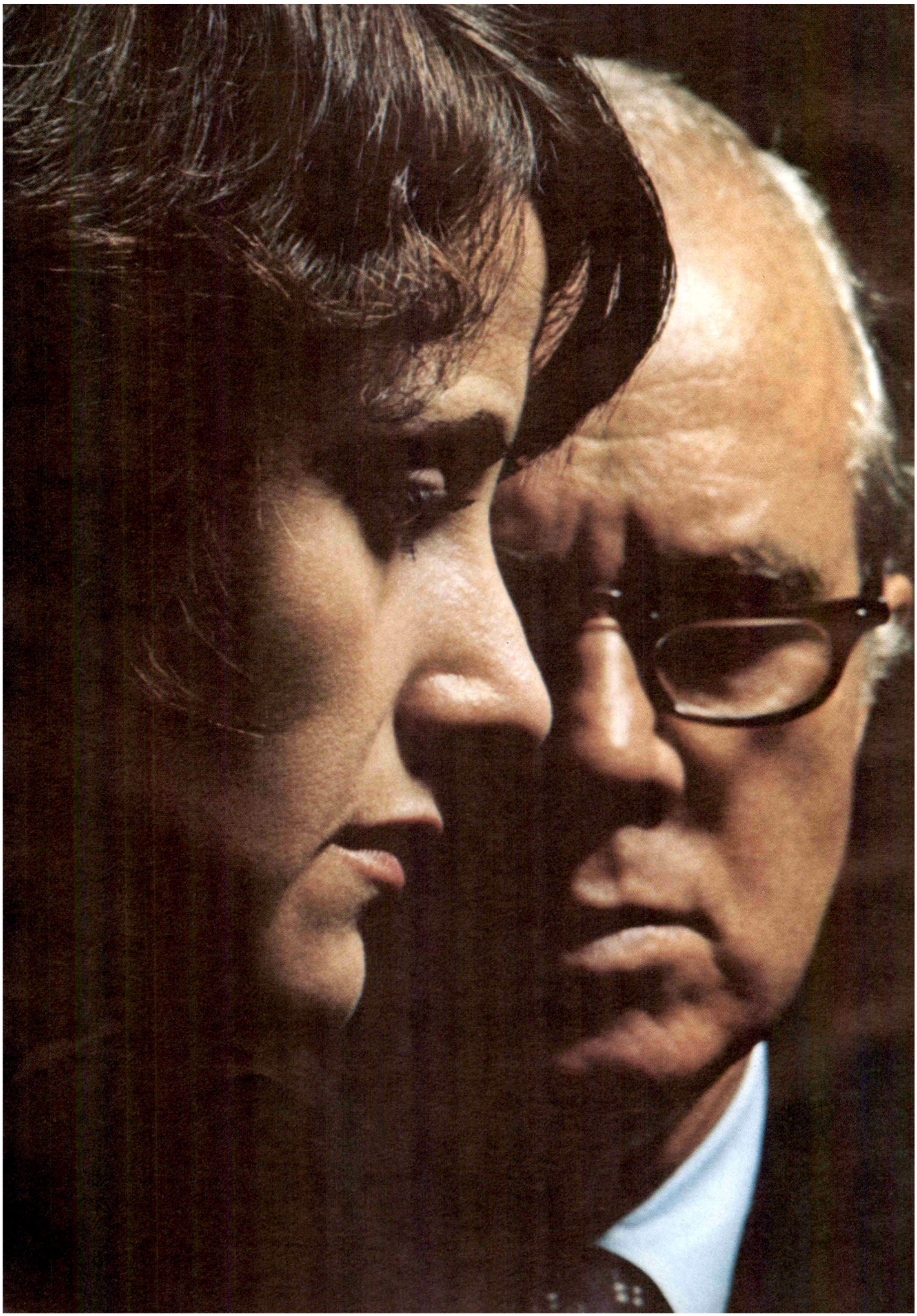
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For a brief summary of prescribing information, please turn to the following page.

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CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastic distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information.
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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function, (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.
The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.
Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.
Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.
A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.
Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:
A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.
To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).
Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.
Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.
If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.
Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.
The pathologist should be advised of estrogen therapy when relevant specimens are submitted.
Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.
Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.
The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.
Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration.

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.
Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.
If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.
Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.
Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.
Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000. No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

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How individual patient variables influenc

It is now well established that certain nondrug factors can affect response to antianxiety medication. Thus, even with agents of proven efficacy, such as Librium (chlordiazepoxide HCl), different patients may exhibit varying degrees of symptomatic relief from excessive anxiety and tension.

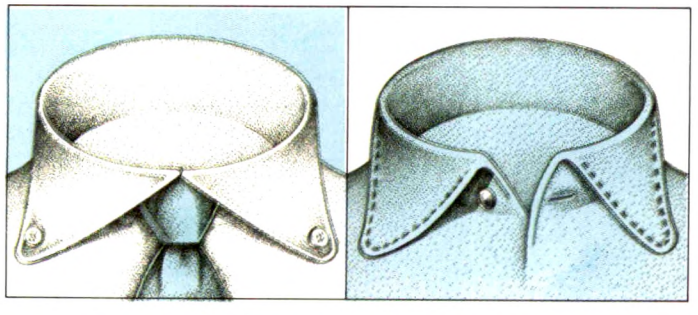
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2. Hollister LE: *Ann Intern Med 79*:88-98, July 1973
3. Greenblatt DJ, Shader RI: *Ibid.*, 77: 91-100, July 1972
4. Rickels K, Downing RW, Howard K: *Clin Pharmacol Ther 12*:263-273, Mar-Apr 1971

Apart from the effect of the physician's personality and prescribing attitudes on patient response,[1] there are certain significant patient variables, *e.g.*, personality type, severity and duration of anxiety, socioeconomic status, attitude toward medication and insight into the nature of the condition under treatment.[2-4] Thus, some clinical experience suggests that physically active extroverts, for whom abatement of anxiety may decrease the will to achieve or take action, may respond negatively – resulting in exacerbation of anxiety.[2] On the other hand, more passively anxious individuals with intellectual and esthetic inclinations have been shown t benefit from antianxiety medications.

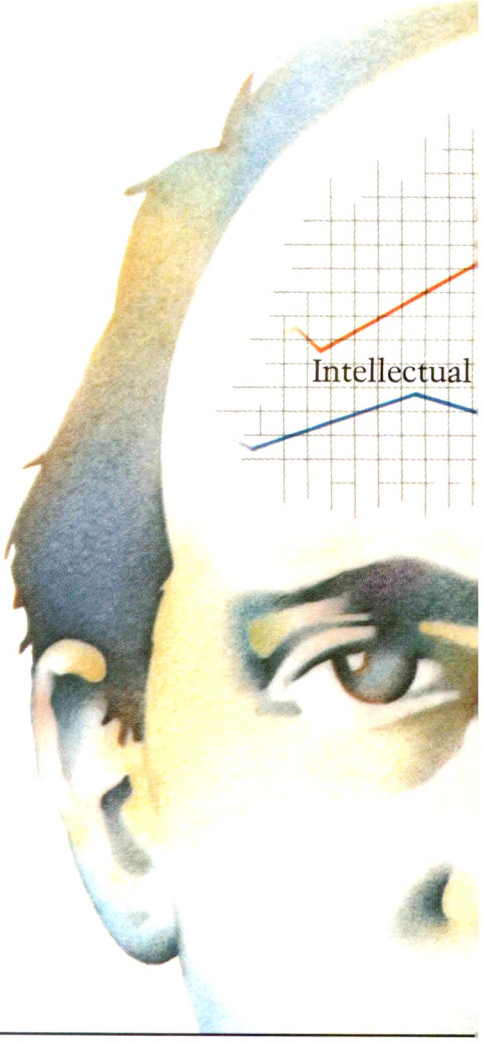
When medication is indicated in the latter group, many psychiatrists place a high value on the benzodiazepines – of which Librium (chlordiaz-epoxide HCl) was the first in clinical use – for their antianxie effectiveness, broad usefulness and wide margin of safety.[2,3]



Attitude to medication



Socioeconomic status



:he effectiveness of antianxiety therapy

Demonstrated predictors of favorable response to Librium (chlordiazepoxide HCl)

In a double-blind, controlled study[4] of psychoneurotic patients with moderately severe anxiety, 111 patients were treated with Librium in a daily dosage of 30 to 40 mg, and 201 patients received a placebo. Outcome criteria included a global improvement measure after 2 and 4 weeks and the 4-week change score of a 10-item physician questionnaire.

Statistical analysis revealed that the greatest drug-placebo difference in relieving anxiety occurred among patients who were more severely ill, those in a higher socioeconomic class and those whose illness had persisted for at least six months. The more educated patient with high verbal ability, greater insight and an accepting attitude toward combined psychotherapy and drug therapy responded *significantly better* to Librium than to the placebo. On the other hand, patients of lower socioeconomic status, with less insight and greater readiness to accept medication alone as sufficient therapy, tend to show a moderately favorable response to both drug *and* placebo.

For proven effectiveness against excessive, obstructive anxiety

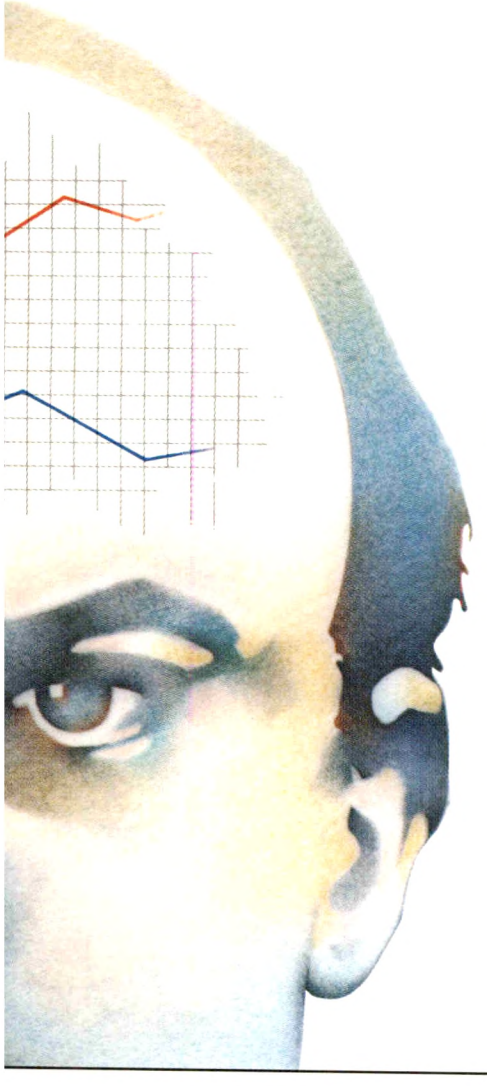
adjunctive

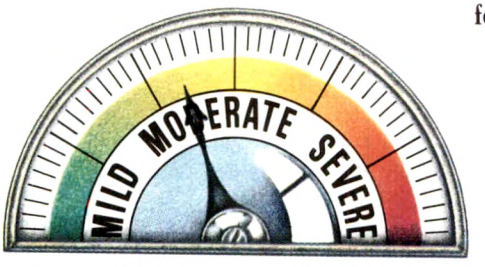
ROCHE **Librium®**

(chlordiazepoxide HCl)

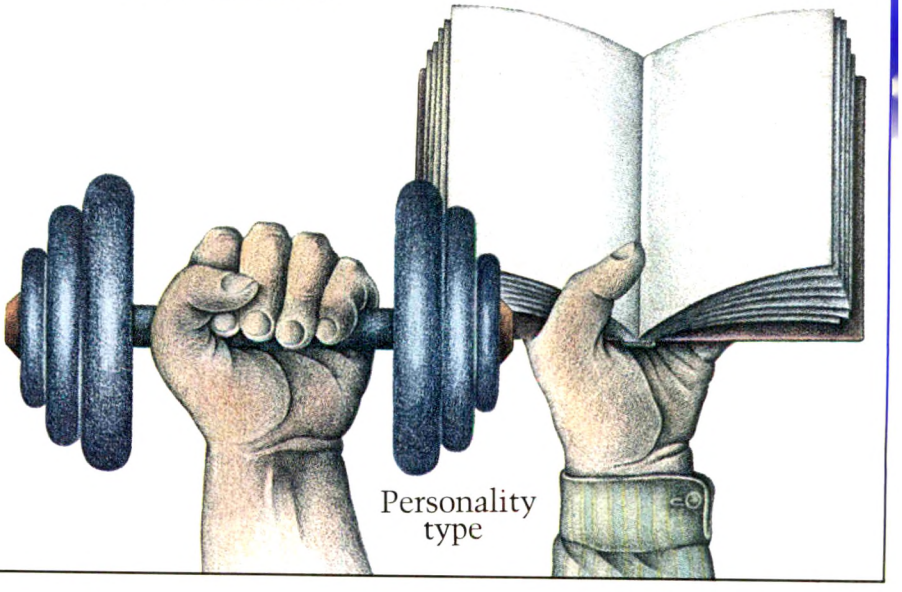
10 mg, 25 mg capsules

Please see following page for summary of product information.





Degree of anxiety



Personality type

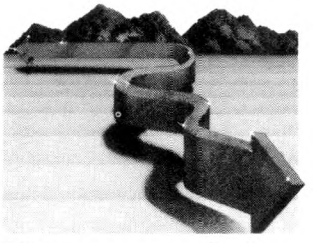
Effective adjunct in psychotherapy

Librium® (chlordiazepoxide HCl)

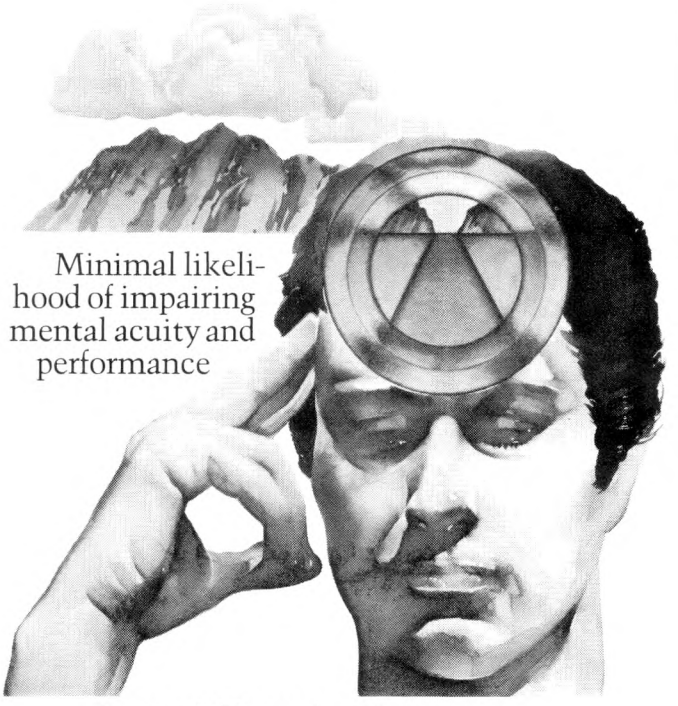
10 mg, 25 mg capsules/up to 100 mg daily in severe anxiety

While drowsiness, ataxia and confusion are the most frequently occurring side effects, physicians should be aware of the possibility of more serious reactions. Before prescribing, please consult complete product information, a summary of which appears below.

When anxiety has been reduced to useful, appropriate levels, Librium should be discontinued.



Wide margin of safety



Minimal likelihood of impairing mental acuity and performance

Dependable antianxiety action

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral— Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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DIRECTOR EMERGENCY SERVICES

The West Philadelphia Community Mental Health Consortium, Inc., a large established Community Mental Health Center in Philadelphia is seeking a creative Board Eligible or Certified Psychiatrist to direct its Emergency Services. Combination of administrative and clinical responsibilities for a 24 hour Emergency Service and Home Visiting Team, liason with other Service Directors, and participation in top management team.

Position carries possible affiliation with Department of Psychiatry of University of Pennsylvania, depending on qualifications. Competitive salary, plus excellent fringe benefits.

Contact Herbert Diamond, M.D., Medical Director, West Philadelphia Community Mental Health Consortium, P.O. Box 8076, Philadelphia, Pennsylvania 19101.

PSYCHIATRIST

Lutheran General Hospital is seeking a full time staff psychiatrist to assist in developing a new outpatient psychiatric program. The Division of Psychiatry has 139 beds including 74 beds in the nationally acclaimed Alcoholic Rehabilitation Center. The hospital is a university affiliated Acute Care teaching hospital located in an attractive suburb of Chicago. The total 675 bed capacity offers a full range of services. Professional and personal rewards are outstanding. The hospital believes in and practices the concept of Human Ecology. Please contact:

L. James Wylie
Vice President Human Resources

LUTHERAN GENERAL HOSPITAL

1775 Dempster St.
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Phone (312) 696-6011

Q QUESTION:

WHAT TRICYCLIC ANTIDEPRESSANT IS AVAILABLE AS AN ORAL CONCENTRATE?

A ANSWER: SINEQUAN® DOXEPIN HCl ORAL CONCENTRATE

10 mg./ml., 120-ml. (4-oz.) bottles



- ☐ Effective in the treatment of clinical depression/anxiety
- ☐ Eliminates potential for "cheeking" medication
- ☐ Colorless, tasteless following dilution
- ☐ Contains no alcohol or sugar
- ☐ Easily mixed with water or juices

BRIEF SUMMARY

Sinequan® (doxepin HCl) **Capsules/Oral Concentrate**

Contraindications. Contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* This drug has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: Usage in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's). Sinequan (doxepin HCl) 25 mg. and 50 mg. also available in bottles of 5000. Sinequan Oral Concentrate (10 mg./ml.) is available in 120 ml. bottles with an accompanying dropper calibrated at 5 mg., 10 mg., 15 mg., 20 mg., and 25 mg.

More detailed professional information available on request.

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A brief reminder...



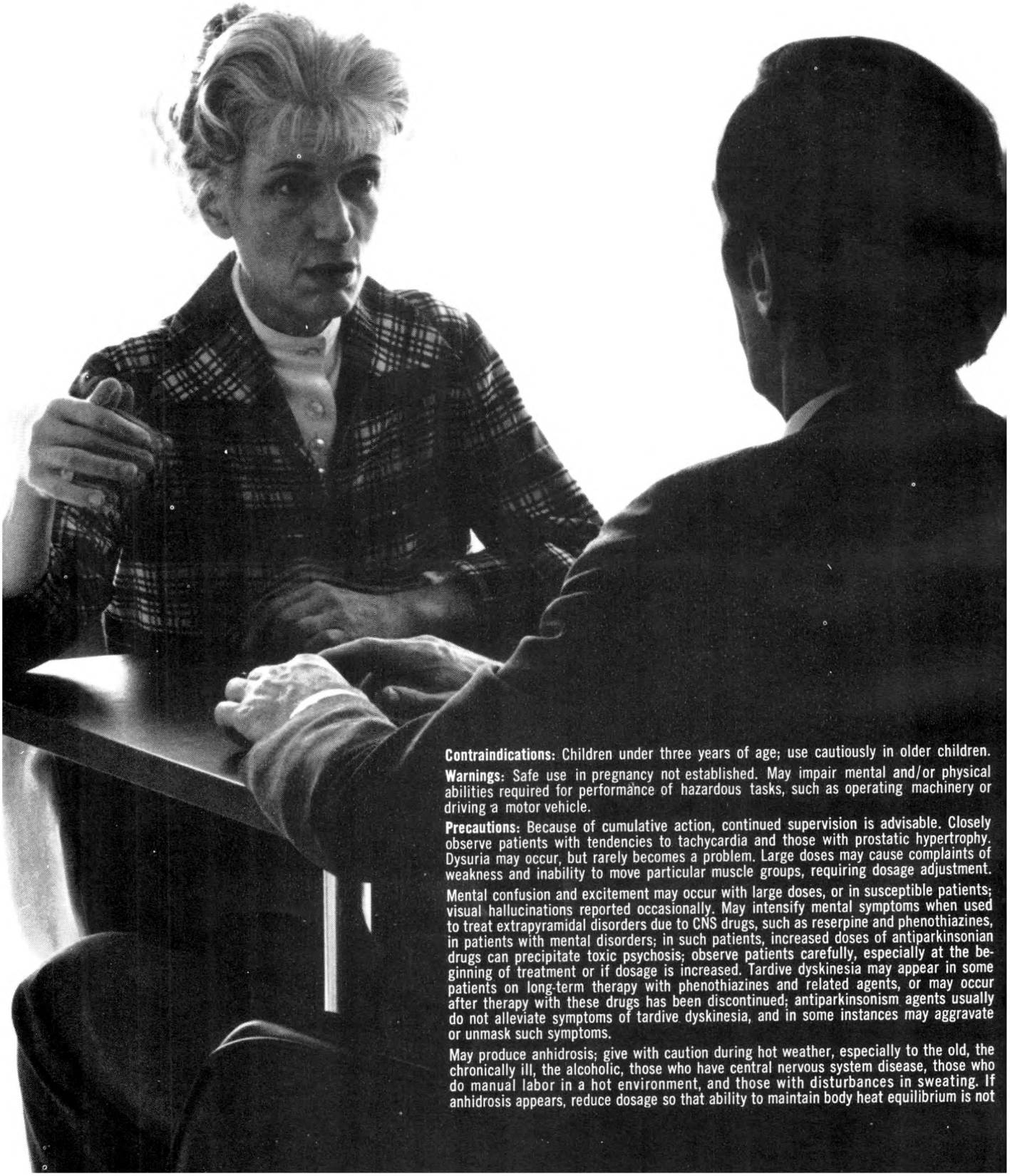
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Single Unit Packages: 1, 2, 5 and 10 mg. tablets

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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)
helps alleviate most phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; Injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

addendum

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to COGENTIN.

For more detailed information, see full prescribing information.

Adapting to age: time and the mind

Aging successfully: is the goal just survival?

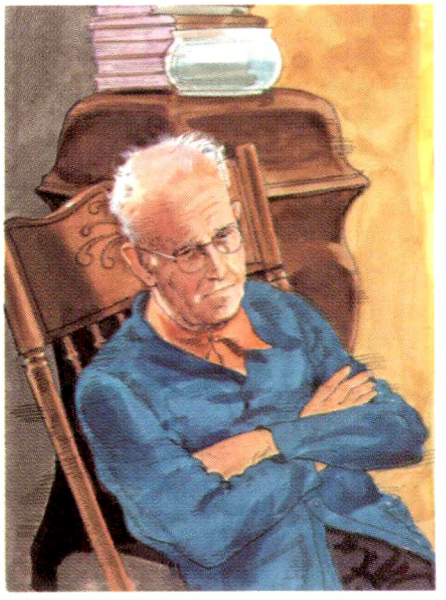
Popular belief would have it that "aging" and "existing" are the same, both marked by deteriorated ability—physical and mental. But is successful aging just existing?

Or is it making the most of one's abilities?

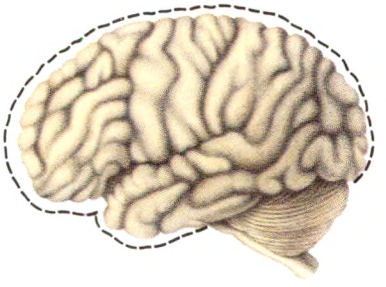
More than just surviving the changes and obstacles of old age, successful aging is *adapting* to the changes and *overcoming* the obstacles. Consider the very fortunate aging individuals who continue active, productive, even socially significant lives. Picasso, painting and sculpting until his death at the age of 91. Stokowski still conducting at 92. Margaret Mead, an active author and anthropologist at 73. Consider, too, those who lack prominence and popular acclaim, but still lead personally satisfying lives. Thus adding meaning to their prolonged existence by following interests and abilities.

How then, can some age so successfully, others less so, and still others merely survive? One reason: individual differences. Not only in abilities, but in opportunities and situations that can either nurture or suffocate ability.

Aging doesn't have to mean ailing bodies and failing minds. True, the cell loss of old age extends to the brain. But







the loss of brain cells doesn't invariably lead to loss of intelligence and alertness. For,

Although the decrease in brain volume is well known,

enormous reserves of cerebral cells help compensate for loss with age. Disease and injury, more than advancing age, actually lessen cerebral capacity.

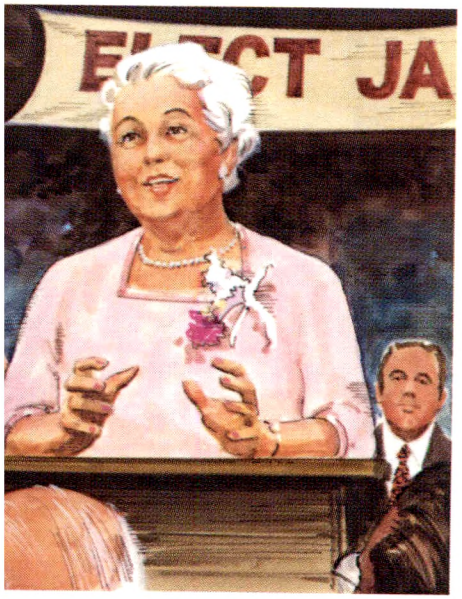
And lack of use contributes to the decline; mental and physical functions that are utilized tend to persist and those not utilized tend to disappear. So, if used, the mind often can remain alert. And, in fact,

Some now believe that intellectual decline can be minimal.

One theory isolates two basic types of intelligence: "fluid" and "crystallized." Both increase into adolescence, but fluid intelligence, formless and independent of education, begins to decline during the twenties. Crystallized intelligence—experience refined through education—continues to grow, and does not decline or even level off during old age. So, according to this theory, total intelligence changes qualitatively. Quantitatively, it remains relatively constant.

But we still see senility and seeming mental decline, sometimes caused by





injury to the brain from accident or a disease like cerebral arteriosclerosis. In some cases, the reason may be personality frustration even more than actual brain deterioration: a decline in *performance* generated by severe stress more than a decline in *cognitive ability.* Clinically significant anxiety, alone or associated with underlying organic disease, is common in the elderly, and can cripple the aged mind, and interfere with the adaptive process. But

When such anxiety is controlled the elderly patient may become more responsive to personal interests and social activities.

To therapy and counselling. To adapting to the changes of age.

If antianxiety therapy adjunctive to your counsel and reassurance is desirable, consider Serax (oxazepam). Serax has been found valuable, particularly in the older patient, in the management and control of clinically significant anxiety, tension, agitation and irritability.

Special care must of course be taken in prescribing antianxiety agents for elderly patients, especially where cardiac complications might ensue from a drop in blood pressure. And careful attention must be paid to dosage recommendations and follow-up observation.

More than eight years of clinical experience have shown Serax to be especially useful in many geriatric patients. Its dosage flexibility* generally permits adjustment to individual patient needs, making Serax a logical choice in the management of clinically significant anxiety in the elderly patient.

In Brief:

Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease. Anxiety associated with depression is also responsive to oxazepam therapy. This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients. Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

*See package circular for full prescribing information.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: Use in Pregnancy: Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Not indicated in children under 6 years; absolute dosage for 6- to 12-year olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Wyeth
makers of Serax® (oxazepam)
for use in clinically significant anxiety

Wyeth Laboratories · Philadelphia, Pa. 19101

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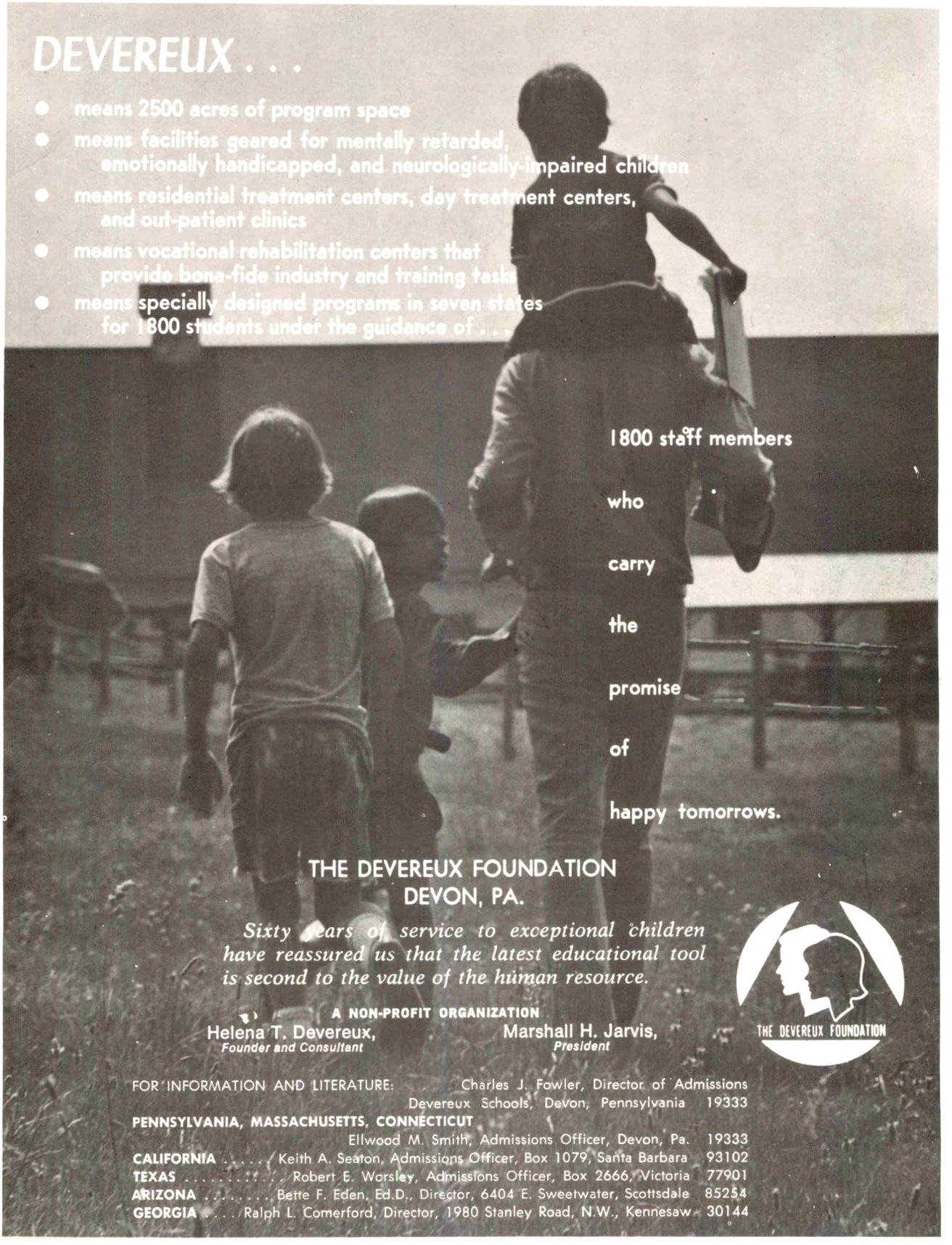
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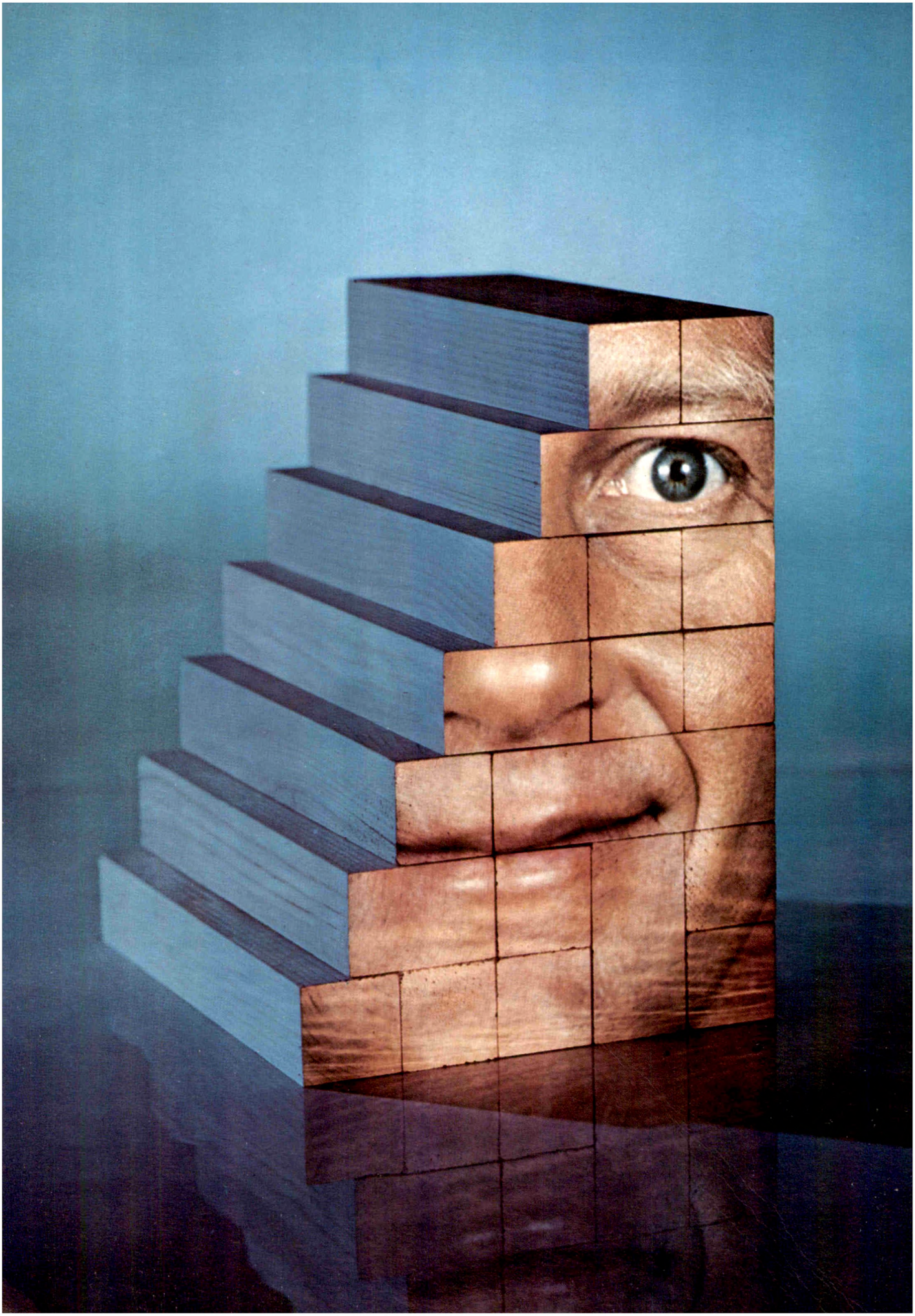
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Final classification of the less-than-effective indications requires further investigation.

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May counteract antihypertensive effect of guanethidine and related compounds.

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Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

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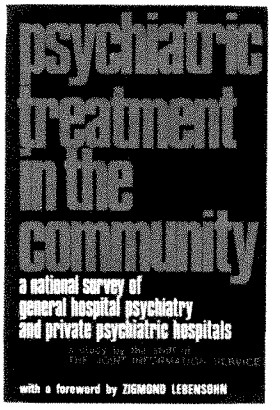
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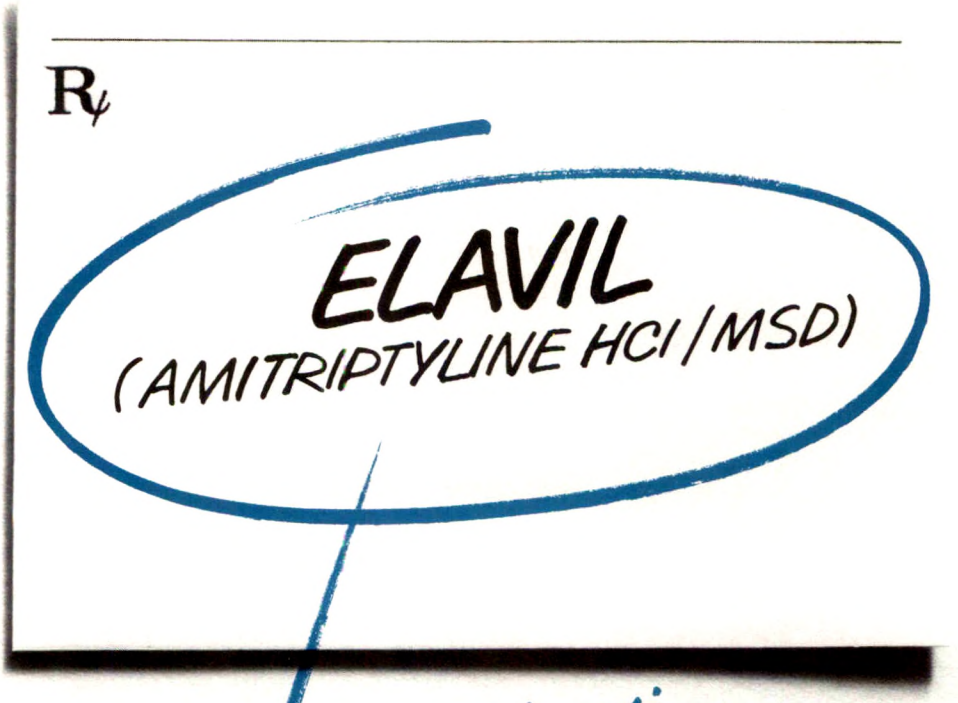
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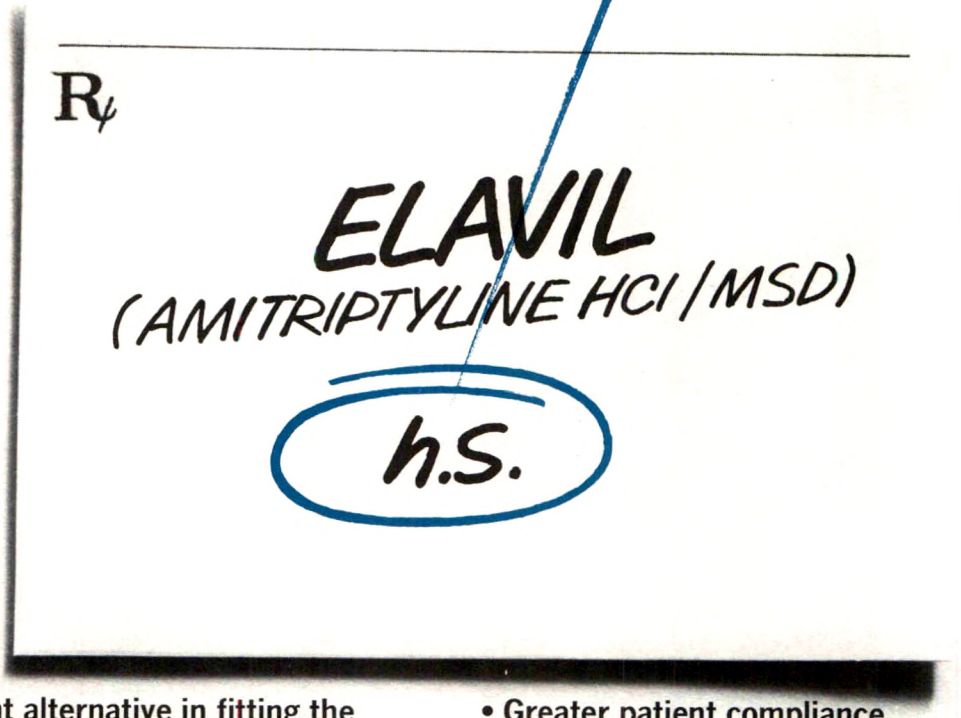
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In the treatment of clinically significant depression...



For highly effective symptomatic relief... the reason to prescribe it

Now added dosage versatility...



- **An important alternative in fitting the medication to the patient's needs**

  Once-a-day dosage at bedtime is an appropriate way to start—and maintain—many patients on therapy. Of course, ELAVIL may be administered two, three, or four times as well as once a day. This dosage versatility allows prescribing precisely for the patient's needs.

- **Once-a-day dosage schedule for adult outpatients**

  Therapy should be initiated with 50 mg to 100 mg at bedtime. This may be increased by 25 or 50 mg added to the bedtime dose as necessary to a maximum daily dose of 150 mg. The usual maintenance dose is 50 to 100 mg a day given at bedtime, though in some patients, 40 mg per day is sufficient.

- **Greater patient compliance**

  The simplicity of once-a-day dosage at bedtime makes it easier for patients to adhere to a regimen—an especially important consideration in depressed patients whose self-motivation may be at a low ebb.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

once a day at bedtime

Please see addendum on following page for other details of dosage and administration including divided daily doses, dosage in hospitalized patients, and dosage in elderly and adolescent patients.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

added dosage versatility in clinically significant depression

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: ***Note:*** Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. ***Cardiovascular:*** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. ***CNS and Neuromuscular:*** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. ***Anticholinergic:*** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. ***Allergic:*** Skin rash, urticaria, photosensitization, edema of face and tongue. ***Hematologic:*** Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. ***Gastrointestinal:*** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. ***Endocrine:*** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. ***Other:*** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. ***Withdrawal Symptoms:*** Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

MSD MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

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IN PRESS...

Psychiatric Aspects of Neurologic Disease

Edited by **D. Frank Benson, M.D.** and **Dietrich Blumer, M.D.**

The contents cover: The Borderland of Neurology and Psychiatry; Organic Brain Syndromes; Acute Mental Concomitants of Physical Disease; EEG Evaluation of the Patient with Dementias; The Hydrocephalic Dementias; Dementia, Depression and Pseudo-Dementia; Disorders of Verbal Expression; Disorders of Mental Functioning Related to Frontal Lobe Pathology; Personality Changes with Frontal and Temporal Lobe Lesions; Temporal Lobe Epilepsy and its Psychiatric Significance; The Neural Basis of Sexual Behavior; Spontaneous and Drug-Induced Movement Disorders in Psychotic Patients; Psychiatric Syndromes of Huntington's Chorea; Organic Brain Disease Mistaken for Psychiatric Disorder.

August 1975, 336 pp., illus. abt. $18.75/£9.05

"A Seminars in Psychiatry" reprint ISBN 0-8089-0860-X

A Concise Handbook of Community Psychiatry and Community Mental Health

Edited by **Leopold Bellak, M.D.**

Topics discussed: Meeting Community Health Center Problems; Current Special Problems and Special Services in Community Mental Health; and Beyond the Community Mental Health Center.

1974, 256 pp., $11.00/£5.30 ISBN 0-8089-0833-2

On Behalf of Children

By **William Hetznecker, M.D.** and **Marc A. Forman, M.D.**

Separate sections cover: Clinical Services; Consultation; New Manpower Resources; Overview.

1974, 216 pp., $9.74/£4.70 ISBN 0-8089-0844-8

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An Annual Publication of the American Association for Social Psychiatry

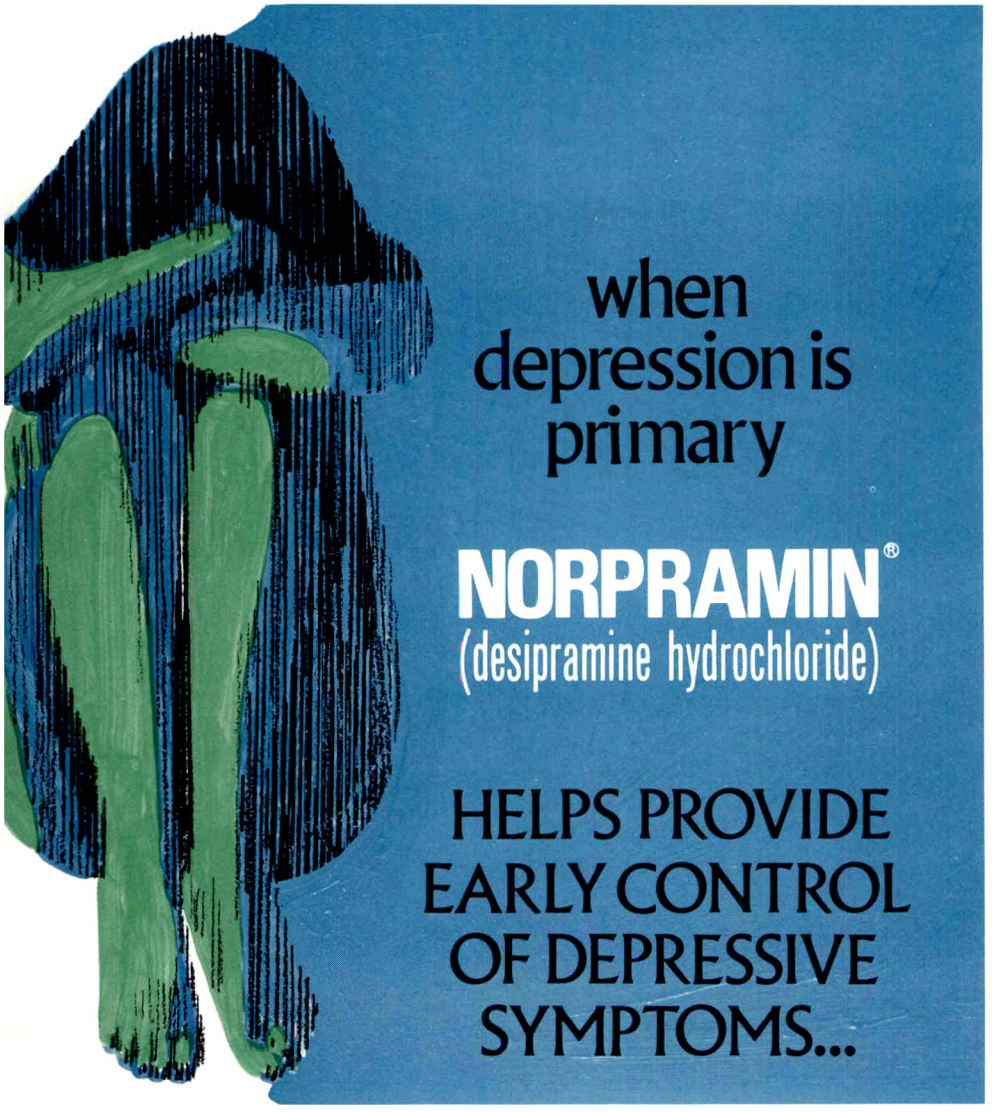
Edited by **Jules H. Masserman, M.D.** and **John J. Schwab, M.D.**

1974, 216 pp., $13.50/£6.50 ISBN 0-8089-0001-3

GRUNE & STRATTON, INC.

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When you see anxiety-look for depression
NORPRAMIN®
(desipramine hydrochloride)



when depression is primary

NORPRAMIN®
(desipramine hydrochloride)

HELPS PROVIDE EARLY CONTROL OF DEPRESSIVE SYMPTOMS...

Anxiety is an invidious symptom. It feeds upon sickness, gnaws, grows and invades every cranny of psychic pathology adding intensity to torment. Anxiety as a symptom secondary to depression may be so dominant that it obscures the primary diagnosis. It may suggest treatment with tranquilizers which often help. But as the vampire of legend had to have a laurel stake driven through its heart to truly die, so anxiety secondary to depression will not cease to nibble and bite until an antidepressant eradicates the primary illness—and symptomatic anxiety starves.

IN BRIEF:

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. If possible, dispense in child-resistant containers. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of phychosis in schizophrenic patients. Use cautiously with anticholinergic or sympathomimetic drugs. Response to alcoholic beverages may be exaggerated. In the concurrent administration of ECT and antidepressant drugs one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of phychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

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It always happens so fast.

And, this time, you're right. It did happen to "the other guy."

You know: The guy who wouldn't hurt a fly, turn down a friendly drink—or take a cab home instead of driving. A nice guy who'd now and then smoke in bed, maybe swim out a little too far, sometimes hurry a little down the stairs.

We know you knew him. And that you'll miss him.

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Contraindications: The only known contraindication is sensitivity to Akineton hydrochloride.

Warnings: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients.

Precautions: Caution should be observed in patients with manifest glaucoma, though no prohibitive rise in intraocular pressure has been noted following either oral or parenteral administration. Patients with prostatism or cardiac arrhythmia should be given this drug with caution. Occasionally, drowsiness may occur.

Adverse reactions: Adverse reactions encountered are primarily dry mouth and blurred vision. These side effects are usually slight and can be overcome by judicious reduction of dosage. If gastric irritation occurs, it can be avoided by administering during or after meals.

Dosage and Administration: Doses required to achieve therapeutic goal are variable and must be individually and gradually adjusted.

Parkinson's disease: 1 tablet, 2 mg. three or four times daily.

Drug-induced extrapyramidal disorders: 1 tablet, 2 mg. one to three times daily.

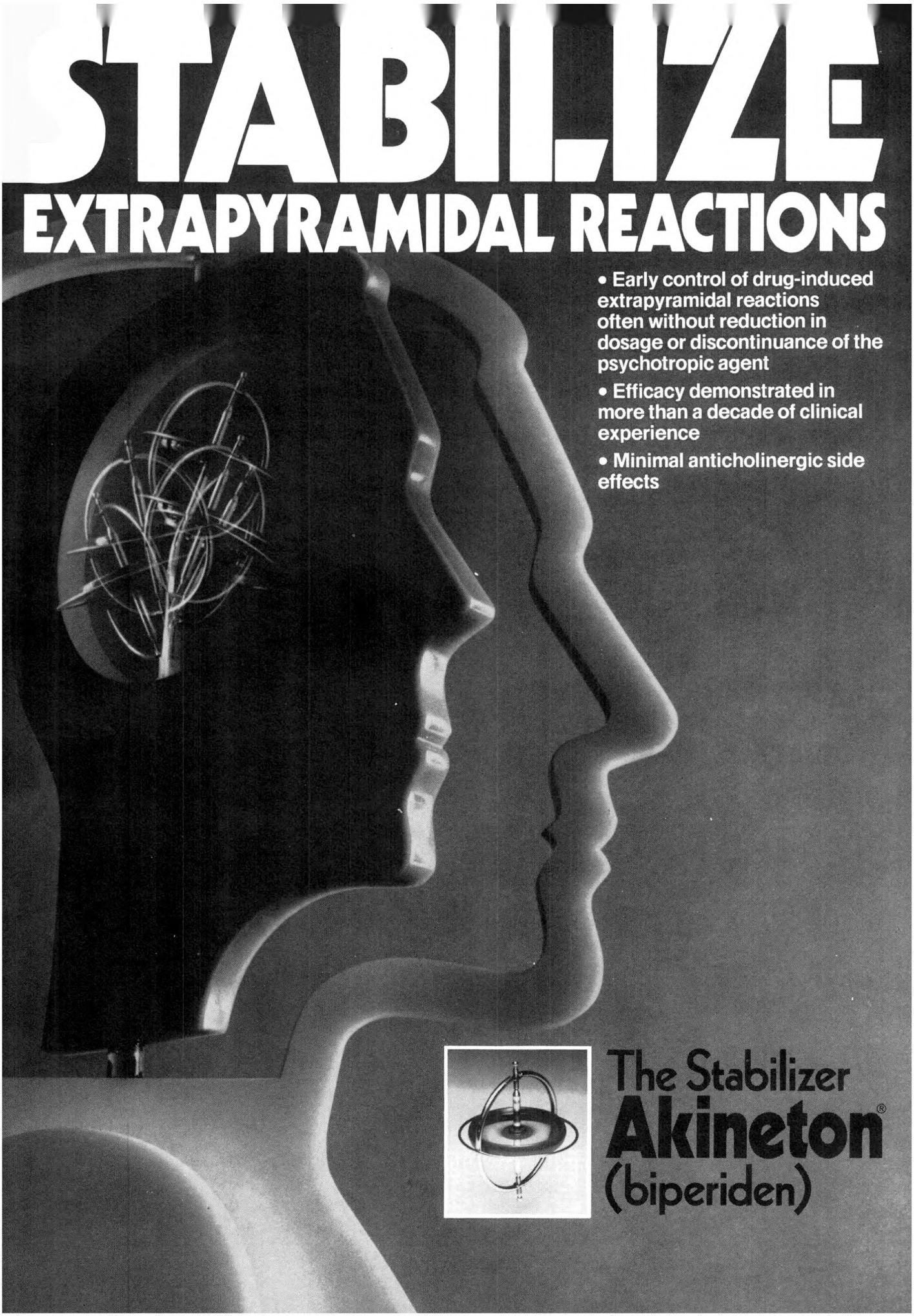
How Supplied:

Akineton hydrochloride tablets, 2 mg. each, bisected—bottles of 100 and 1000.

Akineton lactate ampules, 1 ml. each containing 5 mg./ml. in an aqueous 1.4 percent sodium lactate solution. No added preservative. Boxes of 10.

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EXTRAPYRAMIDAL REACTIONS
• Early control of drug-induced extrapyramidal reactions often without reduction in dosage or discontinuance of the psychotropic agent
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• Minimal anticholinergic side effects
The Stabilizer
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(biperiden)

May be the start of a better life for the epilepti

About nine out of ten epileptics suffer their first seizure in childhood.[1] Certain physical and psychic postseizure evidence—a badly bitten tongue, broken or dropped objects, amnesia, exhaustion—may suggest grand mal. Once the diagnosis of epilepsy has been established, *MYSOLINE (primidone) may mean the start of a seizure-free life.*

Early therapy for control of grand mal, focal and psychomotor epilepsy. Used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. Based years of clinical success, MYSOLINE has ear the reputation of being an *excellent* drug for trol of grand mal epilepsy.[2-4] But its usefulnes not confined to this type alone: MYSOLINE proved to be valuable for control of psychomoto and focal epilepsy[5] as well.

Improves response to concomita therapy. When other anticonvulsants prove be inadequate, adding MYSOLINE to the regin can improve seizure control in grand mal and



chomotor epilepsy. A double-blind comparative study[6] shows that the combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.

Effective changeover therapy. Unsatisfactory performance or important side effects may force discontinuation of the patient's existing anticonvulsant therapy. For more effective control, MYSOLINE may be added to the patient's present regimen, then gradually substituted for the original medication. The changeover to MYSOLINE is frequently warranted when grand mal is refractory to phenobarbital, with or without diphenylhydantoin.[7]

Mysoline®
(primidone)

See last page of advertisement for prescribing information.



Ayerst®

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Mysoline® (primidone) May be the start of a better life for the epileptic

initial and maintenance therapy for grand mal, psychomotor and focal epilepsy

BRIEF SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of **PRIMIDONE**

Anticonvulsant

INDICATIONS: MYSOLINE, either alone or in combination, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Use in pregnancy: The effect of primidone on the human fetus has not been studied, and the benefit of administration of any drug during pregnancy must be weighed against any possible effect on the fetus.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking MYSOLINE and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K_1 therapy for one month prior to, and during, delivery.

In nursing mothers: There is evidence that in mothers treated with MYSOLINE, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone) and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	*2nd Week* 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	*4th Week* 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances: for initiation of combination therapy; during "transfer" therapy; for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.).

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References: 1. Livingston, S., and Pruce, I.: Pediatr. Ann. *2*:10 (Aug.) 1973. 2. Livingston, S., and Pruce, I.M.: Drug Therapy for Epilepsy, Springfield, Ill., Charles C Thomas, 1966, p. 23. 3. Scholl, M. L., in Conn, H. F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. *37*:49 (Jan.) 1970. 5. Forster, F. M.: Med. Clin. North Am. *47*:1579 (Nov.) 1970. 6. White, P. T.: Wis. Med. J. *68*:178 (Apr.) 1969. 7. Millichap, J. G.: Drug Ther. *1*:15 (Oct.) 1971.

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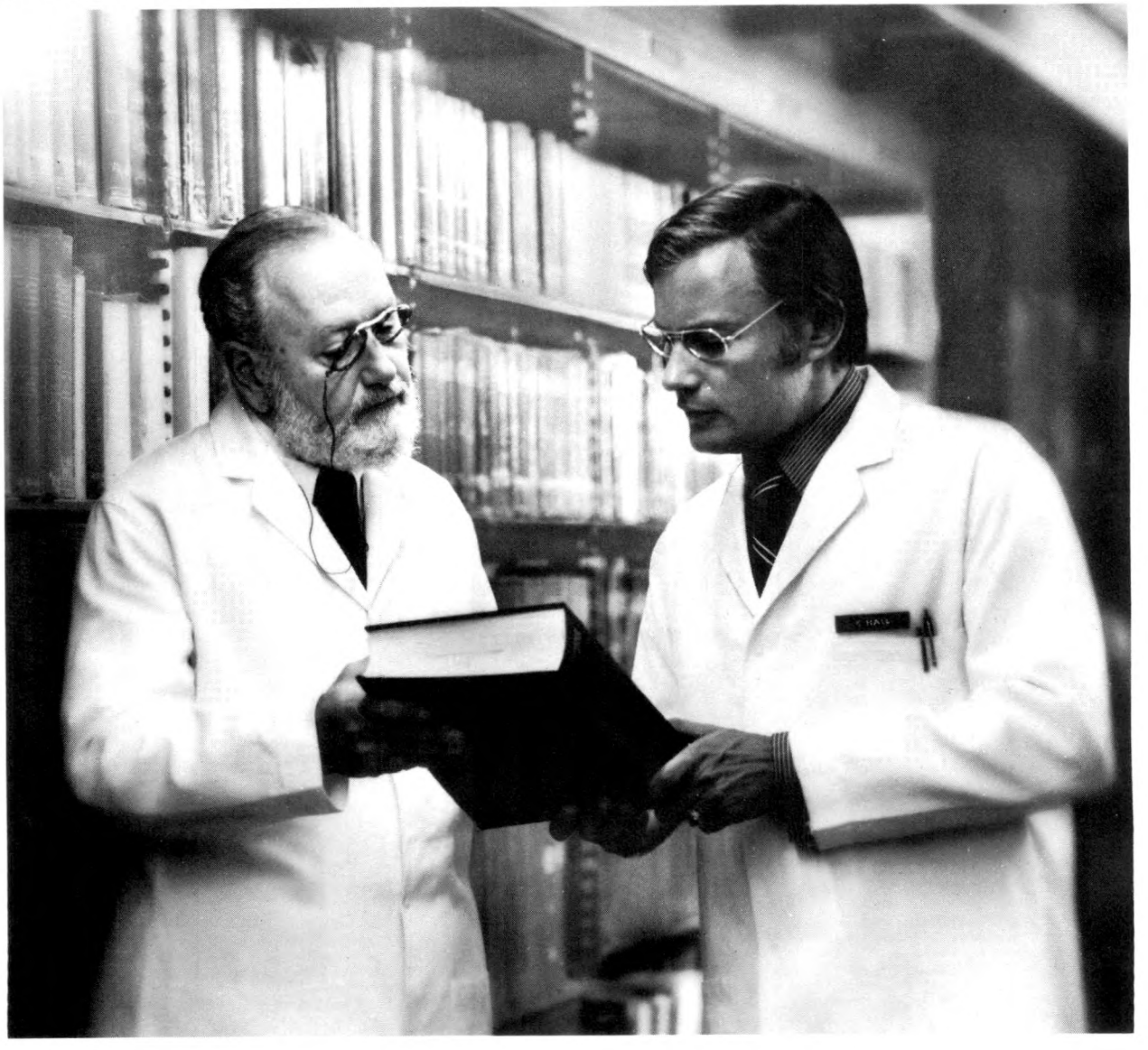
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INDICATION: As a hypnotic for relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence have been reported infrequently. Withdrawal symptoms, when they occur, tend to resemble those associated with withdrawal of barbiturates and should be treated in a similar fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be limited without adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

Usage in Children: Not recommended in children under 3 months of age.

PRECAUTIONS: Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits. Observe usual precautions in hepatic or renal disorders. Perform periodic blood counts if used repeatedly or over prolonged periods.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few, isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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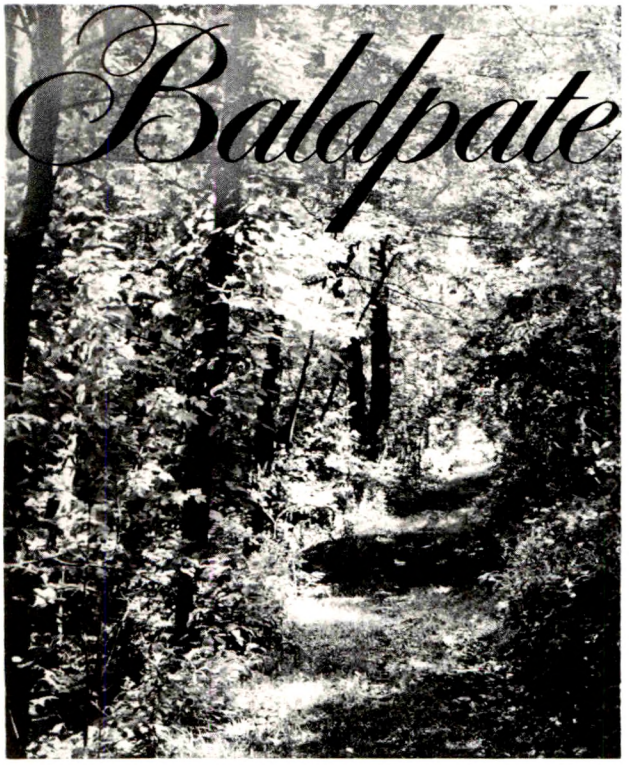
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Contraindications. Contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* This drug has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: Usage in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

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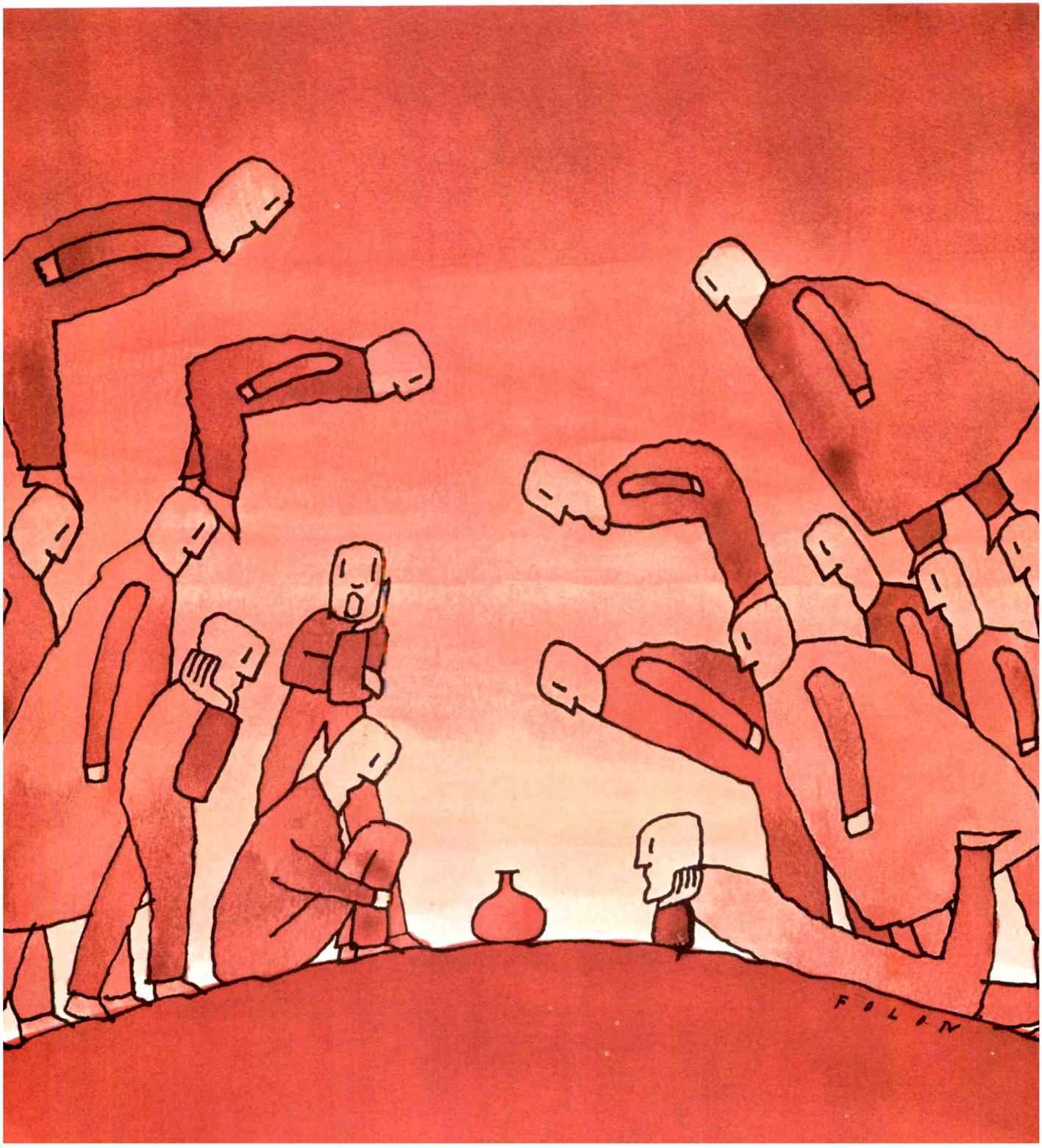
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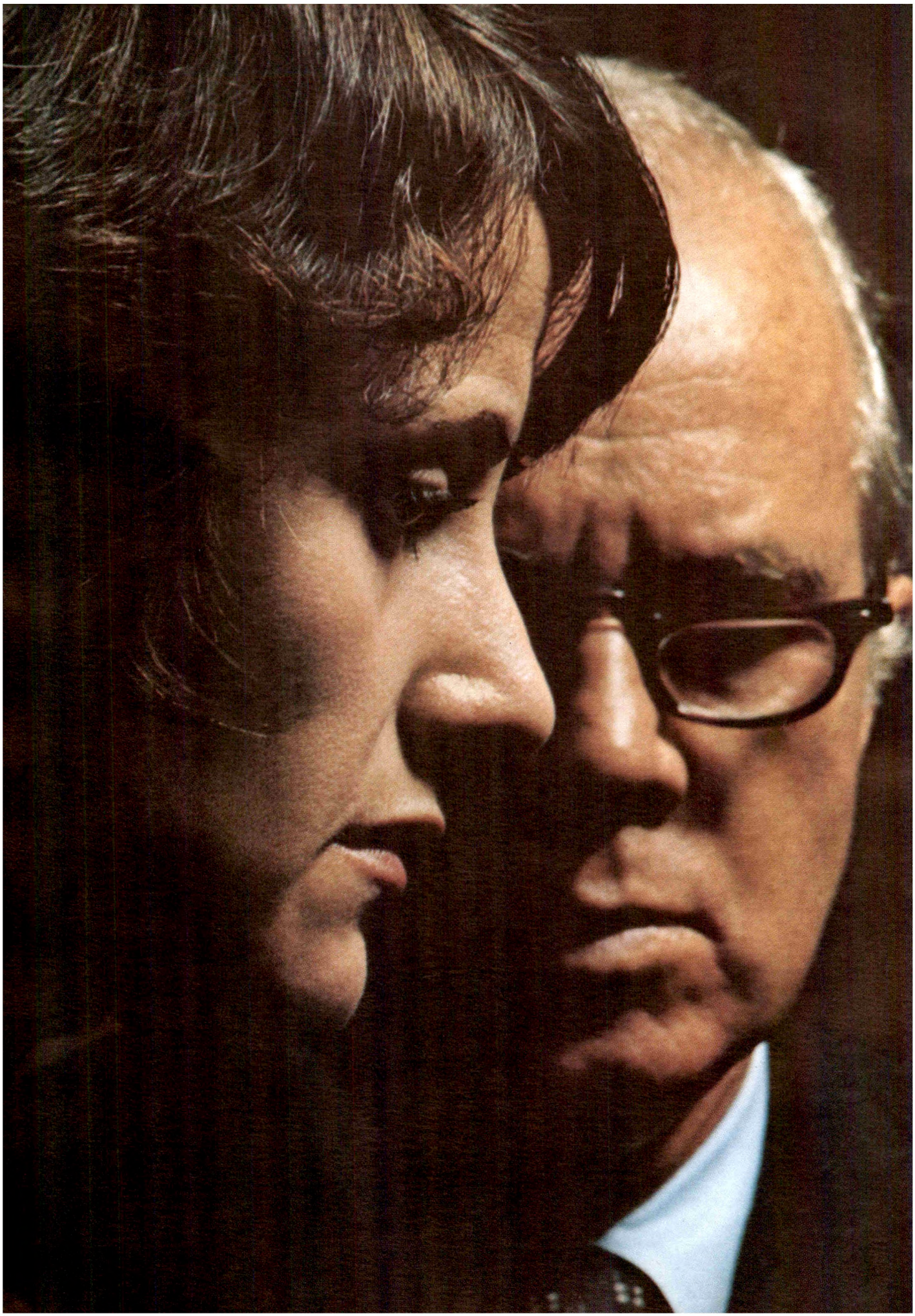
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WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg/Concentrate 5 mg/ml

Once-a-day–to help control symptoms of psychosis

For prescribing information, including adverse reactions and contraindications please see following page of this advertisement.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg Concentrate: 5 mg/ml Intramuscular: 2 mg/ml

PRESCRIBING INFORMATION
Navane® (thiothixene)
Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg (thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children–The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration – As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudoparkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia: antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leucocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration. Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution–For Intramuscular Use Only. Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate appear in the following paragraphs.

Navane Capsules; Navane Concentrate–In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor elevating action of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Picrotoxin or pentylenetetrazol should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is available as capsules containing 1 mg, 2 mg, 5 mg, and 10 mg, of thiothixene in bottles of 100 and 1,000. Navane is also available as capsules containing 20 mg of thiothixene in bottles of 100 and 500.

Navane (thiothixene hydrochloride) Concentrate is available in 120 ml (4 oz.) bottles with an accompanying dropper calibrated at 2 mg, 4 mg, 5 mg, 6 mg, 8 mg, and 10 mg. Each ml contains thiothixene hydrochloride equivalent to 5 mg of thiothixene. Contains alcohol, U.S.P. 7.0% v/v (small loss unavoidable).

Navane (thiothixene hydrochloride) Intramuscular solution is available in a 2 ml amber glass vial in packages of 10. Each ml contains thiothixene hydrochloride equivalent to 2 mg of thiothixene, dextrose 5% w/v, benzyl alcohol 0.9% w/v, and propyl gallate 0.02% w/v.

More detailed professional information available on request.

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Stelazine®

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Six dosage forms and strengths
Tablets: 1, 2, 5 and 10 mg.
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Concentrate: 10 mg./mL.
Single Unit Packages: 1, 2, 5 and 10 mg. tablets

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Adapting to age: time and the mind

Aging successfully: is the goal just survival?

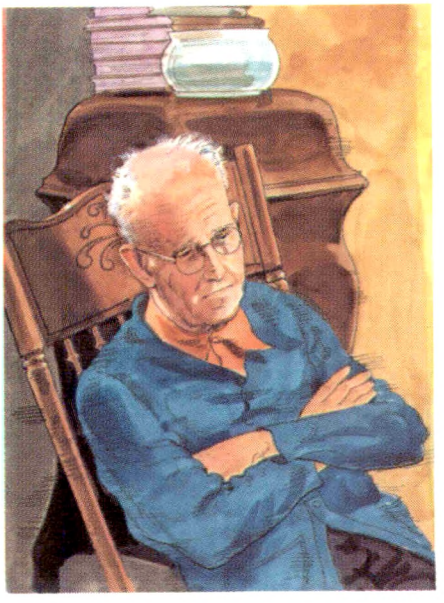
Popular belief would have it that "aging" and "existing" are the same, both marked by deteriorated ability—physical and mental. But is successful aging just existing?

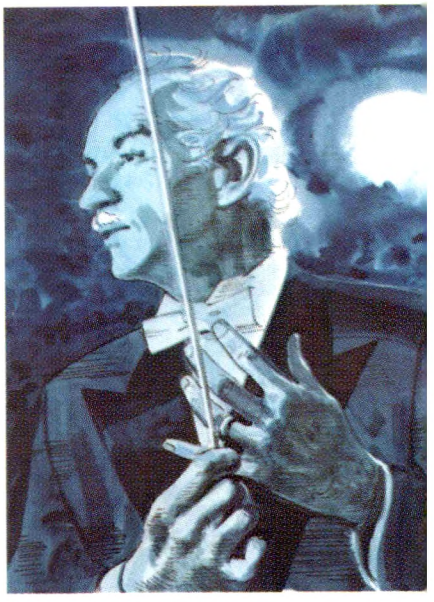
Or is it making the most of one's abilities?

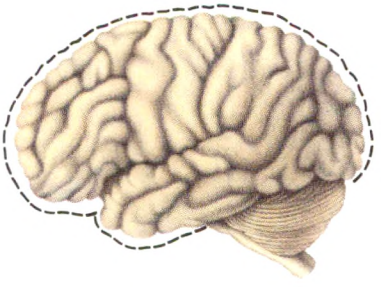
More than just surviving the changes and obstacles of old age, successful aging is *adapting* to the changes and *overcoming* the obstacles. Consider the very fortunate aging individuals who continue active, productive, even socially significant lives. Picasso, painting and sculpting until his death at the age of 91. Stokowski still conducting at 92. Margaret Mead, an active author and anthropologist at 73. Consider, too, those who lack prominence and popular acclaim, but still lead personally satisfying lives. Thus adding meaning to their prolonged existence by following interests and abilities.

How then, can some age so successfully, others less so, and still others merely survive? One reason: individual differences. Not only in abilities, but in opportunities and situations that can either nurture or suffocate ability.

Aging doesn't have to mean ailing bodies and failing minds. True, the cell loss of old age extends to the brain. But







the loss of brain cells doesn't invariably lead to loss of intelligence and alertness. For,

Although the decrease in brain volume is well known, enormous reserves of cerebral cells help compensate for loss with age. Disease and injury, more than advancing age, actually lessen cerebral capacity.

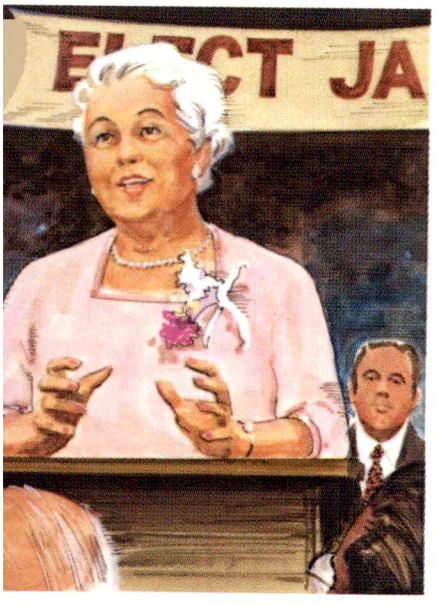
And lack of use contributes to the decline; mental and physical functions that are utilized tend to persist and thos not utilized tend to disappear. So, if usec the mind often can remain alert. Anc in fact,

Some now believe that intellectual decline can be minimal.

One theory isolates two basic types c intelligence: "fluid" and "crystallizec Both increase into adolescence, but flui intelligence, formless and independer of education, begins to decline durin the twenties. Crystallized intelligence - experience refined through education - continues to grow, and does not declir or even level off during old age. Sc according to this theory, total intelligenc changes qualitatively. Quantitatively, remains relatively constant.

But we still see senility and seemin mental decline, sometimes caused b





njury to the brain from accident or a lisease like cerebral arteriosclerosis. In ome cases, the reason may be per- onality frustration even more than ctual brain deterioration: a decline in *erformance* generated by severe stress nore than a decline in *cognitive ability.* Clinically significant anxiety, alone or as- ociated with underlying organic dis- ase, is common in the elderly, and can ripple the aged mind, and interfere with ne adaptive process. But

When such anxiety is controlled the elderly patient may become more responsive to personal interests and social activities. To therapy and counselling. To adapting to the changes of age.

If antianxiety therapy adjunctive to your counsel and reassurance is desirable, consider Serax (oxazepam). Serax has been found valuable, particularly in the older patient, in the management and control of clinically significant anxiety, tension, agitation and irritability.

Special care must of course be taken in prescribing antianxiety agents for elderly patients, especially where cardiac complications might ensue from a drop in blood pressure. And careful attention must be paid to dosage recommendations and follow-up observation.

More than eight years of clinical experience have shown Serax to be especially useful in many geriatric patients. Its dosage flexibility* generally permits adjustment to individual patient needs, making Serax a logical choice in the management of clinically significant anxiety in the elderly patient.

In Brief.

Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease. Anxiety associated with depression is also responsive to oxazepam therapy. This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients. Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

*See package circular for full prescribing information.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: Use in Pregnancy. Safety for use in pregnancy not established.

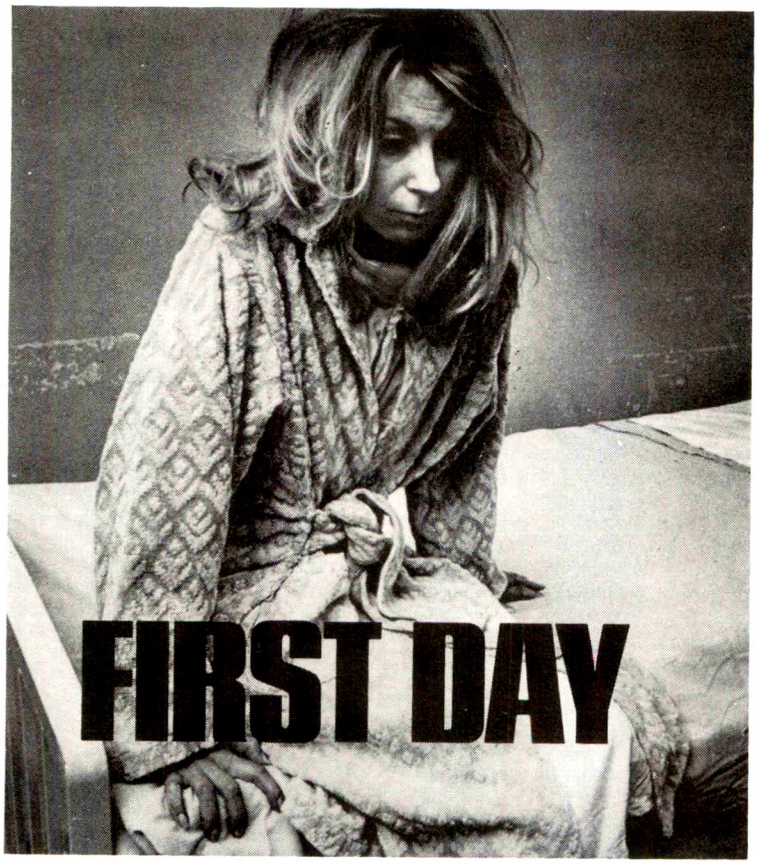
Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Not indicated in children under 6 years; absolute dosage for 6- to 12-year olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Wyeth Laboratories · Philadelphia, Pa. 19101

Wyeth
makers of Serax® (oxazepam)
for use in clinically significant anxiety



First day in the hospital and all efforts will be directed toward returning her to the community.

For psychotic patients with mixed anxiety-depression, Mellaril has been found useful to help patients participate more fully in the entire therapeutic program. Continued medication with Mellaril is often basic to helping patients prepare for and participate in outpatient treatment programs that bridge the gap between hospital and community.

With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

MELLARIL®
(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic patients with mixed anxiety-depression

Before prescribing or administering, see Sandoz literature for full produc information. The following is a brief summary.

Contraindications: Severe central nervous system depressior comatose states from any cause, hypertensive or hypotensive hear disease of extreme degree.

Warnings: Administer cautiously to patients who have previousl exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaur dice) to phenothiazines. Phenothiazines are capable of potentiatin central nervous system depressants (e.g., anesthetics, opiates, a cohol, etc.) as well as atropine and phosphorus insecticides. Dur ing pregnancy, administer only when the potential benefits excee the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopeni and/or agranulocytosis and convulsive seizures. In epileptic pa tients, anticonvulsant medication should also be maintained. Pig mentary retinopathy may be avoided by remaining within the rec ommended limits of dosage. Administer cautiously to patients par ticipating in activities requiring complete mental alertness (e.g. driving), and increase dosage gradually. Orthostatic hypotensio is more common in females than in males. Do not use epinephrin in treating drug-induced hypotension since phenothiazines may in duce a reversed epinephrine effect on occasion. Daily doses i excess of 300 mg. should be used only in severe neuropsychiatri conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especiall with large doses, early in treatment; infrequently, pseudoparkin sonism and other extrapyramidal symptoms; nocturnal confusion hyperactivity, lethargy, psychotic reactions, restlessness, and head ache. *Autonomic Nervous System*—Dryness of mouth, blurred vi sion, constipation, nausea, vomiting, diarrhea, nasal stuffiness and pallor. *Endocrine System*—Galactorrhea, breast engorgement amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*- Dermatitis and skin eruptions of the urticarial type, photosensi tivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Ef fects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines an should be considered: *Autonomic Reactions*—Miosis, obstipation anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfolia tive dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocy tosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplasti anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of elec trocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with pheno thiazines, including Mellaril (thioridazine); these appear to be re versible and due to altered repolarization, not myocardial damage While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, severa sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardio graphic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathi sia, agitation, motor restlessness, dystonic reactions, trismus torticollis, opisthotonus, oculogyric crises, tremor, muscular rigid ity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhyth mical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk be ing greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Dis- turbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpy- rexia; behavioral effects suggestive of a paradoxical reaction, in- cluding excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythema- tosus-like syndrome.

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THE AMERICAN JOURNAL OF PSYCHIATRY

The Psychotherapist's Search for Self-Renewal

BY TRACEY MCCARLEY, M.D.

The role of psychotherapist carries with it special stresses to which many professionals react with depressive feelings, particularly in mid-life. Psychotherapists who participated in small group sessions at two annual institutes of the American Group Psychotherapy Association revealed their depressive feelings in a striking way. Some were able to relate these feelings to early family dynamics that motivated their choice of a caretaking career. The groups concluded that there is a continuing necessity for the caretaker to acknowledge and seek care for his emotional needs. Planners of continuing professional education for psychotherapists should make these needs a central concern.

THE NOTION THAT the role of the psychotherapist carries special stresses is a truism that we all acknowledge. We accept the beginning therapist's need for personal therapy to help him master and use his empathic understanding of his patients and of the individual and group process and to aid him in handling his personal conflicts. However, the therapist's need for emotional support and reclarification and renewal of self-understanding in the later years of his practice is inadequately recognized. Perhaps the disturbingly high number of suicides among psychiatrists could be reduced were it not for the prevalent feeling that what was acceptable in the early years of training is not acceptable in mid-career. In "Analysis Terminable and Interminable" Freud (1) recommended that the psychoanalyst "enter analysis once more at intervals of, say, five years, and without any feeling of shame in so doing." But Freud's advice in this regard is rarely followed.

There are formidable internal and external forces opposing the mature, practicing psychotherapist's return to therapy or analysis. The internal factors include the feeling of humiliation or embarrassment at again identifying oneself as a "patient" and the reluctance to assume a dependent role. The external deterrents include the problem of having social relationships with the colleagues to whom one might choose to go for therapy. A further difficulty is the prevailing myth expressed in the statement, "He was analyzed by so and so." The implication is that the process has been completed and that it is a reflection on either the analysand or the analyst if further therapy is undertaken.

Dr. McCarley is in private practice at 4911 Van Nuys Blvd., Sherman Oaks, Calif. 91403; he is also Associate Clinical Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles.

THE NEED FOR SELF-RENEWAL

Stresses of Middle Age

Erikson (2) has shown us how different stages of life present us with different adaptational tasks. This means that the solution one has worked out in analysis or therapy during the training period may not be appropriate for coping with what Marmor (3) has called the crisis of middle life. Marmor pointed out that in mid-life come such stresses as the physical signs of aging, i.e., the loss of hair and skin tone and the battle against weight gain, intimations of one's own mortality, and the deaths of friends and relatives. During this period, one very powerful stress for most people is the recognition that they may never achieve the high goals they had set for themselves. And all of these stresses come at a time when there is the greatest demand on one's earning capacity to meet the needs of the family, including school-age children.

When one adds to these the kinds of stresses inherent in the practice of psychotherapy, i.e., the daily confrontations with patients' depressions, rages, and demands for support and nurturance, it is obvious that one has a formidable emotional load to carry.

A positive reason favoring the return of the psychotherapist in mid-career to some form of renewing emotional and educational experience is the fact that having now dealt with a great number and variety of patients, he has a rich lode of experience, counterreactions, and countertransferences to examine and learn from. In this area, introspection can carry one just so far, and there comes a

time when the calm view of a colleague with no personal ax to grind is needed to restore perspective. This view can be provided by the special relationship that we call therapeutic but by other settings as well. The kind of group experience described in this paper could be useful periodically to almost all therapists, and it might provide a kind of "preventive maintenance" that would make formal therapy unnecessary.

Group Experiences

Group experiences of various kinds are currently very popular with psychotherapists. They frequently attend weekend workshops, marathons, encounter groups, etc., which are held at training centers, nearby resorts, or right at home when a traveling exponent of one of the "newer methods" comes around. The practicing therapist's wish to learn something about Gestalt therapy, transactional analysis, or some other technique may fuse with his legitimate need for some "emotional feeding" and a chance to reexplore feelings. More traditional meetings, with their rigid formats, do little to fill the need that some of these newer group experiences try to meet.

In contrast to the short-term, intensive nature of the weekend meeting is the leaderless therapy group of experienced psychoanalysts reported by Kline (4). Kline felt that the once-a-week meetings of this group, which continued for three years, were successful in facilitating the further maturation of these already trained psychoanalysts.

There are many other situations in which a psychotherapist may find the opportunity to ventilate and reexamine his feelings, i.e., at lunch with colleagues and at committee meetings, but it is the clinical group at the annual institute of the American Group Psychotherapy Association (AGPA) that I would like to examine with these considerations in mind. My experience indicates that a substantial number of the participants in this annual activity of the AGPA come with a consciously articulated goal of "learning something about group therapy," but their more important, although unconscious, goal is to receive some attention for their more personal emotional needs and conflicts. Psychotherapists tend to feel an excessive responsibility for helping people, and they have a proclivity for spurring themselves to greater and greater effort to "rescue" their patients. This paper will present some observations made on a few therapists in a short-term, intensive educational group experience.

In this group the more pronounced depressive trends in some of the older members were matched by similar dynamics in some of the younger participants. From this interaction there developed a dominant group theme that has an urgent relevance to our profession's plans for continuing education programs and projects.

OBSERVATIONS

The clinical group at the annual institute of the AGPA is composed of no more than 15 participants who have indicated on their applications their desire for a learning experience that will include, to varying degrees, both didactic and experiential components. These applicants are matched with a group leader who has indicated on his questionnaire that he favors a comparable mix of the two elements. For the two consecutive years that I conducted the clinical group I indicated my expectation that the principal type of learning would be experiential but that there would also be a substantial amount of time devoted to didactic material. Sometimes it was not possible to match the preferences of the applicants and group leader. Hence some of the group members had requested a more didactic type of leader. At the other end of the continuum were a number of participants who had stated that they came to have an "emotional experience." The majority, however, had simply indicated that they came to learn about group therapy, a modality with which they had limited experience.

Both years the clinical group met morning and afternoon on two consecutive days for sessions of three or four hours in duration. I told the group at the beginning that our purpose was to learn about group therapy by experiencing, observing, and reflecting together upon what happened in our group during the two days that we were together. In each of the meetings, after the group had worked for a while on a theme, I called a halt to the interaction and invited the members to reflect on what had happened. It is some of the material that came out before this point, when the group was functioning as a working therapy group, that led me to the conclusions regarding depression that I have stated.

The dominant theme that emerged each year concerned the participants' oppressive feelings of being overwhelmed by the responsibilities of caring for psychiatric patients and their deep feelings of discouragement.

The First Year

During the first year this theme emerged as one group member, a psychiatrist in his early 50s, described his reasons for coming to the institute. He came to learn about group therapy so that he could add this technique to his therapeutic armamentarium. He said that he felt discouraged with what he was able to do for his patients and wanted to learn about group therapy so that he might be able to be more helpful to them.

As he talked, his sense of discouragement and depression became more apparent. As this feeling was explored he began to talk about his situation back home, where he had become a sort of father-confessor to almost everyone, it seemed. He spoke of his professional colleagues and their wives and families, all of whom came to him with urgent personal crises. Since he had assumed this role in the small community, he felt there was no one to whom *he* could go to talk about his feelings. He had had some therapy many years earlier, but he now was in partnership with the man who had been his therapist, so he did not want to talk with him about his feelings of discouragement and deprivation. He was in a kind of downward spiral in which the more depressed he felt, the more he had to spur himself to try to do more for others. The more he did for others, the more deprived he himself felt.

In the group he became more aware of this strong feeling of deprivation and realized that he seldom asked for attention to his own needs. He found it hard to accept the view, which was expressed almost unanimously by the group, that he appeared depressed. However, after some gentle insistence, he began to accept the idea that his needs had as much validity as those of his patients. He began to see that he was living by a kind of double standard since he took the stance that his patients should accept without shame their need for help, but he could not do this himself.

This man's discussion of his dilemma sparked another participant's statement that she felt she was also shouldering too great a load of responsibility in her life because her husband was so passive and ineffectual. Her revelation came in a dramatic outburst of tears that ended her almost two days of maintaining a facade of bright, brittle confidence. The group, following my lead, tried to convey to her the idea that she would be more comfortable with herself and more effective with her clients if she did not have to expend so much energy in maintaining such a carefully made up, false front.

The group concluded with a discussion of the process by which these revelations came about. And the theme was expressed that very often those who assume the helper role have difficulty accepting their own need for help.

The Second Year

At the AGPA institute the following year, in an entirely new group, this same theme emerged even more dramatically, with a larger number of participants revealing personal material relevant to it.

The denial by one of the participants that she ever felt anxious or depressed about her patients was irksome to the others, and they and she became irritated with each other. Eventually she angrily accused me of trying to make her be a "patient." Several participants then expressed the view that being a patient was a humiliating thing. At that point I said that it need not be seen as shameful and that I thought of myself as a patient from time to time as I worked on some problem with my feelings. This comment seemed to change the whole atmosphere in the group. Everyone relaxed a bit and began to speak more freely and with more expression of feeling.

A man began to talk about his feelings of being burdened by the expectations of his family and his wife's family. They thought that he should handle all of their emotional and marital problems because he was a psychotherapist. Another man said that he always had been the most successful person in his family and that because of this he was expected to take care not only of his mother's and his ne'er-do-well brother's emotional problems, but their financial ones as well. He was at that moment struggling with their implicit demand that he move them to the state where he lived so he could look after them.

A third group member, an older woman, spoke of her feelings of being trapped because she was the one of her sibship who had taken on the job of living with and caring for her elderly mother. She described a life in which she devoted her working hours to caring for patients and then came home in the evening to care for her invalid mother. She had, or rather took, little time for friendships or social life. It appeared that her decision to come to the AGPA institute to participate in a group sprang from an unconscious, or at least only partly conscious, wish to meet some of her own emotional needs rather than her strictly educational ones.

The Need To Give and Receive Care

In each of the two groups under discussion, a majority of the participants clearly indicated that they identified to some degree with this theme of feeling overburdened with a need to give. This identification was revealed by verbal contributions, repeated nods of agreement, or rapt attention. Two or three of these participants had been in practice for many years and were at a mid-life crisis. Others were younger but nevertheless had very similar dynamics. There were one or two others who seemed less involved in this issue. It was clear that they had quite different personality dynamics. For instance, one of these was a psychiatrist in an administrative position in a drug rehabilitation program. He did not seem to understand what we were talking about and was quite antagonistic at having been placed in a group where there was so much emphasis on the expression of here-and-now feelings.

Nevertheless, all but a small minority agreed on what might be called the "caretaker's need to be cared for." The group consensus that we should all accept this need within ourselves without shame produced an almost tangible sense of profound relief in the room.

DISCUSSION

These and other experiences in leading groups of psychiatric residents and other psychotherapists, as well as introspection into my own unconscious, have led me to formulate some hypotheses relating to common psychodynamic mechanisms in some professional psychotherapists. Understanding these mechanisms helps to explain the phenomena that I observed in the clinical group of the AGPA institute. My conclusions are as follows.

There are deep-seated, unconscious reasons, rooted in family dynamics, that motivate a person's choice of a caretaking career role such as that of psychotherapist. A significant number of psychotherapists are drawn to the role of caretaker because they were assigned this function early in life in their families. The role of caretaker allows for some symbolic gratification of one's own needs through identification with the client or patient to whom one is giving. And, over time, a fairly stable balance may be struck between giving care to others and receiving care. However, this balance is frequently precarious because the originally assigned role carries with it a proviso that the caretaker must be the "strong one" who keeps out of consciousness *his* need to be cared for.

At any stage of life, but particularly at mid-life, this precarious balance may be upset—by the loss of a sup-

portive relationship, disappointment in one's ability to help in certain situations, or by other factors. At this point the caretaking professional person may become depressed. If he can allow himself to acknowledge his depression, he can seek therapy or other ways of meeting his perceived needs. If, however, he cannot admit such a need to himself, he must seek help in a disguised form. This is precisely what I think a certain number of applicants to the AGPA institute are doing.

For these psychotherapists, as well as for those with other motivations for becoming caretakers, the opportunity to reexplore their feelings periodically in the supportive, therapeutic atmosphere of a group may be very desirable, not only for the therapist's personal comfort but so that he can function better in his role with his patients. The needed experience does not have to be therapy per se; it may instead be in a new kind of continuing education for which we as yet have no satisfactory name. It may be in the form of refresher courses or periodic peer supervision sessions in which the planners and leaders consider that attention to the emotional needs of the therapist is not only a legitimate but a central focus of the work.

We are now experiencing a growing recognition of the need for continuing education for professionals of all kinds. In planning the continuing education of those who devote most of their professional lives to psychotherapy it must be recognized that the psychotherapist uses his feelings, his self, to a degree that is unique. And that self has to be adequately cared for to function well.

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Cocaine Psychoses: A Continuum Model

BY ROBERT M. POST, M.D.

The author describes an orderly progression of clinical syndromes (euphoria, dysphoria, paranoid psychosis) with cocaine use that is related to dosage, chronicity, and genetic and experiential predispositions. That affective alterations are caused by a drug which also produces a schizophreniform psychosis suggests a continuum with implications for understanding the endogenous psychoses. The author emphasizes that alterations in the same neurotransmitter substances may be involved in these multiple psychiatric syndromes, which contrasts with previous "one illness, one transmitter" models.

PHARMACOLOGICAL MODELS AND HYPOTHESES of psychiatric illness have tended to focus on the idea of a single biochemical disorder in a single psychiatric illness. However, the finding that multiple psychiatric syndromes can be associated with a single drug—cocaine, for example—has received scant theoretical attention.

The amphetamine psychosis model has implicated dopamine (1–3), the 6-hydroxydopamine self-stimulation model has implicated norepinephrine (4), and the lysergic acid diethylamide model has implicated serotonin (5) as significant single neurotransmitters in schizophrenic illness. Similarly, single deficits or excesses of specific catecholamines or indoleamines have been postulated in depressive and manic illness (6–9). This kind of pharmacological specificity in theorizing about psychiatric syndromes undoubtedly has utility and heuristic value, but it may also partially obscure the importance of observations relating the same compounds to different illnesses. For example, chronic administration of L-dopa to neurological and psychiatric patients has resulted in the precipitation and/or exacerbation of several different kinds of psychiatric syndromes, including depression, mania, and acute psychosis (10–13). Similarly, in a particular set of circumstances, cocaine can be associated with a syndrome of manic-like euphoria, depressive-like dysphoria, or schizophrenic-like paranoid psychosis (1, 14–22), the symptoms of which are presented in appendix 1.

The potential for stimulants to induce euphoria or dysphoria as well as a schizophreniform psychosis has not been systematically included in the theoretical formulations of "model" psychoses. This paper will review the different syndromes evoked by cocaine and some of the important determinants of response, including drug administration variables (especially dose and duration), underlying genetic and experiential components, and acute clinical-state variables. It will emphasize the progressive evolution of the cocaine syndromes from euphoria to dysphoria to paranoid psychosis as cocaine effects increase in increasingly vulnerable individuals. This progression suggests that alterations in the same neurotransmitters may be involved in each of the cocaine-induced syndromes.

It is suggested that consideration of the different psychiatric syndromes evoked by a pharmacological agent might yield information about the determinants underlying the differentiation and expression of analogous spontaneous or stress-related syndromes. Study of the biological mechanisms related to cocaine-induced behavioral changes may also be relevant to non-drug-induced behaviors. The idea that pharmacopathogenicity may recapitulate psychopathogenicity will be explored. It should be emphasized that this paper makes no claim that cocaine can induce or precipitate mania, depression, or schizophrenia per se, for in several respects cocaine-induced symptomatology does not perfectly mimic that of the functional psychoses. It is suggested, however, that the cocaine syndromes mirror many aspects of the endogenous psychoses closely enough to warrant comparison and that the model derived from such study may be useful in conceptualizing biochemical-behavioral interactions. In addition to cocaine, L-dihydroxyphenylalanine (L-dopa), methylphenidate, and the amphetamines have been implicated in manic-, depressive-, and schizophrenic-like syndromes and will be referred to when clinical data on cocaine are incomplete.

COCAINE EUPHORIA

As described initially by Freud (16), ingestion of from 50 to 100 mg of cocaine hydrochloride is accompanied by a profound sense of elation, increased mental agility, and physical endurance. Freud stated:

> I take very small doses of it regularly against depression ... with the most brilliant success. [The effects were] exhilarating and lasting euphoria, which in no way differs from the normal euphoria of a healthy person.... You perceive increase in self-control and possess more vitality and capacity for work.... This result is enjoyed without any of the unpleasant after effects that follow exhilaration brought about by alcohol.... Absolutely no craving for the further use of

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> cocaine appears after the first, or even repeated, taking of the drug. (23, pp. 54, 56)

Cocaine's mood-elevating properties have been lauded by the Inca Indians in the 1600s and the drug culture of the 1970s, which heralds it as the euphoriant of choice—"king cocaine" (24). However, clear-cut mood elevation was not demonstrated when cocaine was administered orally in doses recommended by Freud to 10 moderately to severely depressed patients hospitalized at the National Institute of Mental Health (NIMH), although one patient did have brief periods of hypomania during cocaine administration (25).

After subcutaneous administration of many sympathomimetic amines, the effects of which are subjectively undifferentiable from those of cocaine, addict volunteer subjects experience a profound euphoria (26). Intravenously injected cocaine produces an ecstatic high which is of brief duration but is so intensely pleasurable that the user may repeatedly "shoot-up" at intervals of 10 to 15 minutes, expending his entire cocaine supply over several hours (14, 21).[1] In studies at NIMH in which 12 depressed patients were given cocaine intravenously, only one experienced a pure euphoria and an anesthetic sense of relief from problems, unaccompanied by dysphoric components (25). This euphoria was experienced after a small dose of cocaine (5 mg), which caused only mild changes in pulse and blood pressure. Although in this case the clinical trial was immediately discontinued and placebo infusions were substituted, it has been reported that typical manic-like symptoms may emerge after higher doses or more chronic cocaine administration, including intense garrulousness, hyperactivity, insomnia, mood lability, predisposition to violence, and grandiose delusions (27). In fact, early workers labeled the symptoms of cocaine abuse "cocainomania" (27). Increased sexual arousal may also accompany cocaine use (14, 15, 17, 19, 21).

COCAINE DYSPHORIA

In a prior study of orally adminstered cocaine in depressed patients, only 1 of 10 became significantly more depressed, agitated, and mute (25). This occurred, however, during a second trial with higher doses of cocaine after an initial trial with lower doses had been without antidepressant effect. Increasing anxiety, suspiciousness, and dysphoria have been reported after increasing doses of injected cocaine (14, 18), and this may partially account for the frequent simultaneous use of opiates with cocaine to modulate and mellow its effects. High doses of stimulants pharmacologically related to cocaine (amphetamine and methylphenidate) also reportedly produce consistent increases in rated dysphoria and nervousness when administered subcutaneously to addict volunteer subjects (26). Cocaine self-administration in animals decreases as the dose of cocaine per injection is increased (28–30).

An intense mobilization of affect and tearfulness was frequently observed in depressed patients receiving intravenous doses of cocaine sufficient to substantially increase pulse and blood pressure (25). Crying started abruptly, coincident with the peak changes in vital signs. The intensity and uncontrolled nature of the reaction as well as frequent attention to issues of sadness and loss were perceived by some depressed patients as dysphoric and were reflected in increased ratings of depression, sadness, anxiety, and difficulty concentrating (25). (At lower cocaine doses associated with milder changes in vital signs, positive affective responses to intravenous cocaine were more likely.)

It is doubtful that dysphoria associated with peak stimulant effects is in any direct way analogous to the dysphoria of the endogenous depressive syndrome, but it may be related to that seen in the subgroup of agitated depressed patients and to the depressive affect so commonly admixed with acute, fulminant manias (31, 32). Mania that has prominent dysphoric components is the most likely to progress to a point where it is difficult to differentiate from acute paranoid schizophrenia.

With chronic cocaine abuse, a syndrome of insomnia, painful delusions, apathy, and melancholy can occur (18). It should be noted that these depressive-like symptoms are noted during cocaine administration and that withdrawal phenomena (which are interesting in their own right) are not being referred to here. A dysphoric phase has also been documented in the studies of experimental induction of amphetamine psychosis in addict volunteer subjects (33–36). This phase occurs during the transition from initial euphoria to paranoid psychosis. In one study, a period of clear depression was also noted in all six volunteers who ingested more than 50 mg of *d*-amphetamine (33).

> That is, they became quite hypochondriacal, spent much of their time in bed, lost interest in TV or ward activities, were anorexic, irritable, fault-finding, and would relate to personnel in a clinging, dependent manner. This dysphoric affect was modulated, however, and responsive to external events. (33, p. 901)

Patients then entered a prepsychotic phase during which they became taciturn, seclusive, and preoccupied with details of their rooms or of the study procedure (33).

COCAINE PSYCHOSIS

When cocaine is abused chronically, a paranoid psychosis that is almost indistinguishable from acute paranoid schizophrenia (14, 19, 36) can result. After acute intravenous cocaine administration, the development of a paranoid psychotic state (referred to by users as the "bull horrors" because of intense fear of police) can occur even more rapidly than after amphetamine administration (37). After chronic cocaine administration, delusions of persecution may be vague or systematized and may be

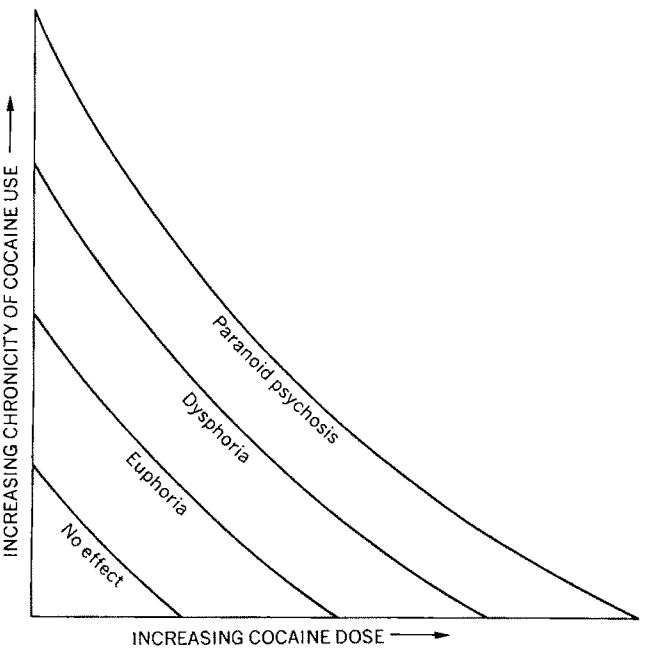
[1]The large total amount of cocaine that can be administered in this fashion has been mistakenly accepted as evidence for tolerance.

accompanied by auditory, visual, or olfactory hallucinations. The user has a clear sensorium and is not confused or disoriented as in a toxic psychosis or delirium, which can also occur after an overdose but is of less theoretical interest. A peculiar but infrequent aspect of the cocaine psychosis is the delusion of parasitosis and sensations of insects under the skin (formication) which may lead addicts to repetitively pick at their skin (36). Addicts may even probe their skin with needles for "cocaine bugs." The addict may experience

> irritability, erroneous conclusions, suspicion, bitterness towards environment, a false interpretation of things, groundless jealousy. . . . A cocainist who has snuffed 3.25 gr. cocaine armed himself for protection against imagined enemies . . . another broke furniture and crockery to pieces and attacked a friend. (27, p. 84)

Violent behavior may be prominent during the height of the cocaine psychosis, apparently triggered by paranoid trends. Stereotyped compulsive behavior analogous to that seen in experimental animals can develop. Addicts may repetitively pursue the same task and be endlessly absorbed by minutiae, as depicted in the case of Sherlock Holmes (38). Hallucinations usually stop when use of cocaine ceases, but delusions may persist.

FIGURE 1
Interaction of Dose and Chronicity in Cocaine-Induced Psychopathology



DETERMINANTS OF COCAINE RESPONSE

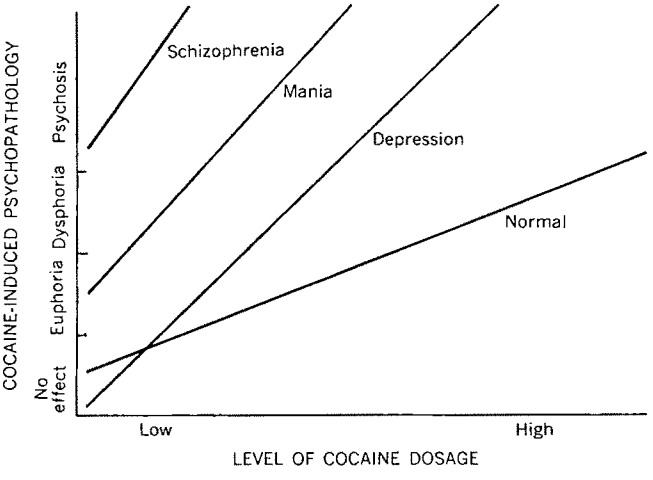
Drug Administration Variables

From the foregoing descriptions, it is clear that increasing the dose and/or chronicity of cocaine administration is associated with increasingly severe affective and cognitive alteration (see figure 1). Initial effects in the euphoric spectrum give way to dysphoria with increasing cocaine use; the paranoid psychosis is reached after high dose and/or chronic administration. At the highest doses, a toxic delirium, convulsions, and death from cardiorespiratory arrest can occur.

The relationship may also be summarized by organizing the response to cocaine along the continuum proceeding from euphoria to dysphoria to psychosis. Again, a positive correlation of cocaine dose and severity of disorganization is suggested (see figure 2). Chronic compared to acute cocaine administration in each case would increase the slope and shift the curve to the left toward greater disorganization at a given dose. Parenteral compared to oral administration would similarly shift a given dose-duration curve toward increased likelihood of euphoric, dysphoric, and psychotic reactions at a given dose.

The rate of change of drug effect appears to be a particularly important determinant of cocaine effect. The "rush" may be related to initial rapidly occurring changes, while the cocaine-induced tearfulness and mobilization of affect in depressed patients corresponds with peak cocaine effects as determined from pulse and blood pressure (25). Delusional thinking and aggressive behavior after amphetamine use are often related to sudden rather than gradual increases in dose (39).

FIGURE 2
Hypothesized Interaction of Dose and Psychiatric State in Cocaine-Induced Psychopathology



Predisposition

In addition to factors related to drug administration, a series of variables relating to a patient's personality and experiential-genetic predispositions seems crucial in determining the response to a given agent. Freud was cognizant of the importance of these factors in relation to cocaine's effects, stating,

> I could not fail to note, however, that the individual disposition plays a major role in the effects of cocaine, perhaps a more important role than with other alkaloids. The sub-

> jective phenomena after ingestion of cocaine differ from person to person, and only a few persons experience, like myself, a pure euphoria without alteration. Others already experience slight intoxication, hyperkinesia, and talkativeness after the same amount of cocaine, while still others have no subjective symptoms of the effects of cocaine at all. (16, p. 16)

This experience is consistent with the finding in depressed patients of varied psychological and physiological responses to intravenous cocaine, where the minimal dose that increased pulse and blood pressure 10 points ranged from 2 mg to 16 mg (25). It would be important to distinguish effects related to differences in blood levels and metabolism of cocaine from those related to differences in patients' sensitivity or predisposition.

Differences in genetic or experiential predisposition can clearly alter one's response to a drug such as L-dopa (10). Depressed patients with a past history of mania (bipolar) uniformly responded to therapeutic trials of L-dopa with hypomanic episodes; patients without a history of mania (unipolar) did not become hypomanic in response to L-dopa (10). Genetic determinants of responses to stimulants are also highlighted by the demonstration of significant differences in hyperthermic response to amphetamine in different genetic strains of mice (40). Prior experience might also predispose selective behavioral response to the drug either on a pharmacological or conditioning basis. Kramer (39) observed that once a patient experiences a paranoid decompensation on amphetamine, even a small dose of the drug taken after a prolonged abstinence may be associated with a recurrence of a paranoid reaction.

Clinical State

Superimposed on genetic and environmental predisposing factors are those relating to the acute clinical status of the patient, such as the type of psychiatric illness, the degree of recent stress or loss, the occurrence of a vulnerable phase of a circadian or ultradian rhythm, and, of particular importance in clinical trials, the patient's expectations or set in the context of a given experimental setting (41). The chronicity of stress would also be an important determinant of the response. For example, acute social stresses in rats, such as fighting and overcrowding, lead to increasing excitation, depletion of norepinephrine, and probability of death after amphetamine administration (42). Chronic social stresses in rats, such as living in groups and being the recipient of peer aggression, are associated with behavioral resistance to amphetamine and altered amine response (42, 43).

On the basis of the observation that a regular, predictable progression (euphoria, dysphoria, psychosis) occurs with increasing intensity of cocaine effect, it is suggested that preexisting, active psychopathology would alter the dose-pathology relationships as depicted in figure 2. For example, an acute schizophrenic patient would have baseline psychotic symptomatology prior to drug use and would further disorganize in the psychotic spectrum after stimulant administration; therefore, he would not experience typical euphoric-dysphoric effects. This schema would also predict that the psychotic decompensation would occur at lower doses than in a healthy individual. Similarly, a manic patient's dose response prediction would begin in the euphoric-dysphoric range, reflecting preexisting psychopathology, and stimulants would exacerbate the manic state, ultimately leading to psychotic disorganization at relatively lower doses than for normal individuals. Figure 2 suggests that, to a certain extent, depressed patients might require a higher cocaine dose to achieve initial euphoric effects than would well individuals, but a lower dose to exacerbate dysphoria. It might also be predicted that patients who are clinically well but predisposed to mania, depression, or schizophrenia would tend to be more sensitive to cocaine than the nonpredisposed subject as depicted by a steeper slope in figure 2.

Although there is not a great deal of systematic data relating clinical state to cocaine response, various predictions depicted in figure 2 have been supported in patient populations studied with drugs similar to cocaine, such as amphetamine (36) and methylphenidate (44). For example, Janowsky and associates (44) reported that changes in psychosis ratings from baseline to 15 minutes after receiving .5 mg/kg methylphenidate were greatest in acute schizophrenic subjects, less in manic subjects, least in depressive subjects, and absent in control subjects. Also consistent with the schema presented was the finding that remitted schizophrenic, manic, and depressive subjects showed proportionately less psychosis after methylphenidate than the respective groups of actively ill patients, but still more than normal subjects (44).

DRUG MODELS OF ENDOGENOUS STRESS

Might we not consider this formulation, emphasizing the varieties of psychiatric response to a single drug, as a model for naturally occurring, stress-induced responses? It would appear that the stimulants, such as cocaine, may be particularly useful models for endogenous stresses. Many of the biological changes associated with cocaine administration appear to mimic those often associated with stress. Cocaine has a generally alerting, sympathomimetic, predominately catecholaminergic action (14, 45, 46). Its acute versus chronic administration may affect neurotransmitter levels and turnover in ways parallel to that of acute and chronic stress. In the most global terms, acute stress tends to increase discharge of catecholamines while chronic stress tends to deplete amines (47). Preliminary evidence indicates this pattern may also occur with amphetamine-like stimulants (48). Finally, cocaine appears to have the intriguing property of reverse tolerance, i.e., increased effect after repeated administration of the same dose (49–52).[2]

It is possible that the progressive disturbances of mood and cognition with increasing cocaine administration and

[2]This property of cocaine may bear certain similarities to the "vicious circle" or positive feedback aspects of some psychopathological adaptations wherein stress may increase the vulnerability to further stress.

the drug and patient variables that affect them may be useful models for the progression of endogenous psychotic disturbances and their mitigating clinical factors. If this line of reasoning has some validity, it might suggest that some of the variables determining the type of psychic response to cocaine-like stimulant drugs would also be important in determining the response to stress. The severity and chronicity of stress in an appropriately susceptible individual might then help predict the type of psychiatric syndrome that would be produced in a manner similar to that suggested for cocaine. Certainly, one of the issues for further investigation based on the pharmacological model presented here would be the possibility of a stepwise continuum for the manic, depressive, and schizophrenic psychoses. The overlapping clinical symptomatology in the acute psychoses and the derived continuum models have been discussed by others (53). The new concepts derived from the cocaine model are 1) the orderly progression of symptomatology, 2) the importance of shifts between affective and schizophreniform states, and 3) the possibility that subtle differences in the same transmitter substances may be related to the different illnesses.

BIOCHEMICAL CORRELATES

Cocaine potentiates the effects of norepinephrine, dopamine, and serotonin at the synapse by blocking reuptake of neurotransmitter into the presynaptic ending (14, 54). It has other direct pre- and postsynaptic effects on several neurotransmitter systems (25). Cocaine, therefore, has complicated and multiple effects even on the better explored transmitters, and the relative role of a given amine in the euphoric, dysphoric, or psychotic syndrome is not yet known.

The finding that drugs with different chemical structures (cocaine, amphetamine, L-dopa, phenmetrazine, and methylphenidate) have all been associated with the onset of schizophreniform psychoses (and euphoria and dysphoria) suggests that the effects are not related to a specific toxic metabolite of one compound (35, 55) but rather to mechanisms of action they have in common. This would also be suggested by the finding that many of the effects of these drugs on human and animal behavior are inhibited by blocking catecholamine receptor sites (neuroleptics) or catecholamine synthesis (α-methyl-p-tyrosine [AMPT]). Cocaine and compounds with related effects enhance dopamine at the synapse either by increasing synthesis, blocking reuptake, increasing release, or stimulating dopamine receptors. They also have effects on noradrenergic as well as serotonergic and cholinergic systems (1, 42–46, 56, 57). Thus, the recent formulations of the amphetamine model psychosis linking one transmitter (dopamine) to one illness (schizophrenia) should be extended (1).

The same transmitter (dopamine) may be linked to the euphoric-dysphoric syndromes as well as paranoid psychosis. The well-known clinical data that neuroleptics are effective in mania as well as schizophrenia (and that selected agents such as thioridazine may possess some efficacy in depression) support the idea that the same pharmacological mechanisms may be involved in several of the endogenous psychotic syndromes.

Other transmitters affected by cocaine (norepinephrine and serotonin) may similarly influence specific components of both the affective and schizophrenic illnesses. The cocaine model presented would thus emphasize the role of neurotransmitter substances in relation to each other, their relative balances, and the time course of their alterations as being critically involved in the regular progression of behavioral change, rather than a "one amine, one illness" formulation. For example, one hypothesis to be tested further is that a relative predominance of noradrenergic to dopaminergic effects may be associated with the early euphoric effects of cocaine, while the ratio might be reversed later corresponding to cocaine's psychotogenic effects.

Animal Models

Cocaine's dramatic effects on animal behavior make it well suited for dissection of biochemical-behavioral relationships. It is noteworthy that cocaine produces hyperactivity at low doses in many laboratory species, compulsive stereotypes at higher doses, and, with chronicity, cataplexy (52). Thus, clear sequential changes are also observed in animals after increasing dose and duration of cocaine. While the direct comparison of these behaviors to human clinical symptomatology remains a dubious proposition, the unraveling of their biochemical determinants may provide valuable clinical leads. For example, an inhibitor of catecholamine synthesis, AMPT, decreases cocaine-induced hyperactivity and stereotypy in the rat, while an inhibitor of serotonin synthesis, p-chlorophenylalanine, does not (58). AMPT also blocks stimulant-induced euphoria in amphetamine addicts (59). The involvement of cholinergic transmission is highlighted by the demonstration that physostigmine, an inhibitor of acetylcholine esterase, will also block cocaine-induced hyperactivity (58). These effects are of particular interest because physostigmine acutely blocks manic behavior in patients with affective illness and also blocks stimulant-induced psychotic disorganization in schizophrenics (60, 61).

Study of acute and chronic cocaine administration in nonhuman primates is currently in progress in order to evaluate behavior in a species closer to man and to assess simultaneous alterations in catecholamine and indoleamine metabolism (62). Preliminary observations indicate that, much like humans, different monkeys appear to have individual styles of response to cocaine and that the same dose of cocaine administered chronically produces a progression of effects from a hyperactive-stereotypic reaction to an inhibitory reaction with catalepsy, hallucinatory-like glances, and an increased susceptibility to cocaine convulsions. Cocaine can also induce seizure activity that is confined to limbic system structures such as the olfactory tubercle, nucleus accumbens, and amygdala and is associated with profound behavioral change and not with convulsions (63–67). A further linkage of

cocaine-induced limbic seizure activity and psychopathology is the observation that drugs which alter cocaine seizure threshold have major psychotropic effects (neuroleptics and thymoleptics), while routine anticonvulsants (diphenylhydantoin and phenobarbital) do not significantly affect cocaine seizures and are not useful antipsychotic agents. Pharmacological or functional disconnection of cortical-subcortical integration due to altered limbic system activity could profoundly affect cognitive and affective integration in the cocaine and functional psychoses.

Thus, consideration of the physiology and anatomy as well as the pharmacology of cocaine's effects may add the extra spatiotemporal dimensions necessary to define more specific biological-behavioral correlates. Under specified conditions, cocaine can produce different clinical syndromes that occur in a regular sequence (euphoria, dysphoria, psychosis) with increasing cocaine administration. Such a progression from affective to schizophreniform syndromes has clinical and biological implications. It is a fascinating prospect that a drug popularized by Freud and described both as a "gift from the sun god" and as the "third scourge of mankind" may play a role in the definition and integration of biochemical, anatomical, physiological, and host interactions in the spectrum of psychoses.

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APPENDIX 1

Symptoms of Cocaine Clinical Syndromes

Cocaine euphoria
- Euphoria
- Affective lability
- Increased intellectual function
- Hyperalertness
- Hyperactivity
- Anorexia
- Insomnia
- Hypersexuality
- Proneness to violence

Cocaine dysphoria
- Sadness
- Melancholia
- Apathy
- Inability to concentrate
- Painful delusions
- Anorexia
- Insomnia

Cocaine schizophreniform psychosis
- Anhedonia
- Lack of disorientation
- Hallucinations
- Concern with minutiae
- Stereotyped behavior
- Paranoid delusions (parasitosis)
- Insomnia
- Proneness to violence

A Multidimensional Problem-Oriented Review and Evaluation System

BY SHELDON I. MILLER, M.D., AND ROY H. SCHLACHTER, M.S.W.

The need for evaluation of psychiatric services is becoming more and more apparent as third-party coverage becomes more available. A variety of expensive and complex data and computer systems have been developed. Small institutions and programs, however, cannot afford them. The system described in this report uses diagnosis and a standardized problem list in order to define the treatment outcome of a variety of therapies delivered in an interdisciplinary setting. The system, which has been developed and is operating at low cost, satisfies a variety of needs.

WITH THE ADVENT OF increasing pressures for peer review of psychiatric treatment, the importance of building a method of evaluation into a delivery system is becoming more clear. Currently, most efforts in peer review are being directed toward inpatient populations, but the interest in outpatient care is evident as well. Much of the federal government's interest in this area centers around cost containment; this can easily result in the simple counting of either average days of stay in the hospital or average number of visits per diagnosis for a hospitalized or an ambulatory patient. It is therefore incumbent upon the profession to develop a more multidimensional approach to the evaluation of both inpatient and outpatient care.

A number of sophisticated and rather costly systems have been developed that collect extensive data and function as a direct aid to the care provider as well as being useful in evaluation procedures (1–5). However, since the total mental health field faces the need for evaluation of its service delivery, it is necessary to develop a variety of low-cost, yet comprehensive, data and evaluation systems that can serve these functions more generally. The system to be described in this report is one such example. It functions as the primary data collection and evaluation tool for a department of psychiatry in a large general hospital affiliated with a medical school; the department primarily serves ambulatory patients.

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DEVELOPMENT OF THE SYSTEM

When the department was established about five yea ago, it was decided that from the outset a system woul be established that would allow for evaluation of servic functions and treatment outcome. The department composed of individuals representing different thec retical orientations toward psychological processes. It interdisciplinary in function and professional compos tion (6); social workers, psychiatrists, psychologists, an nurse-clinicians all act in a generalist role as well as in th specialist roles specific to their training and backgroun Each individual acts as the primary evaluator and defin tive therapist for a variety of patients. Patients are a signed to the staff on a rotating basis unless the initial r ferring information indicates a specific need for psychiatrist, social worker, psychologist, or nurse. Whe necessary, the special expertise of another professional requested in consultation. It is sometimes necessary t transfer the primary responsibility for a patient to ar other professional. This diversity served as an adde stimulus to our desire to be able to evaluate the effectiv ness of the individuals approaching similar problem from different points of view.

The diversity in staff composition is matched by a d versity in the patients seen. The department operates a active consultation service, day and evening outpatie facilities (7), childrens' services, a satellite clinic that geographically separate from the institution, and an alc holism program. Because of this diversity in service th patients seen represent virtually every diagnostic en tity (8).

Our goals in developing a review and evaluation sy tem for this department were multiple. We wanted 1) simple demographic description of the patient popu lation, 2) a tool for evaluating outcome, 3) a managemer tool, 4) a means of gathering information that would hel in planning programs on the basis of current experienc and 5) a way of determining cost effectiveness without n glecting the details of the patients' actual needs and prob lems. We wished to accomplish these goals with a min mum of professional time so as not to unduly raise th staff's resistance to the evaluation. Similarly, we did n want to increase the cost by using undue amounts of pr fessional time in record-keeping. It must be pointed ou that our goals did not include, as in some systems (1, 3 providing aids in diagnosis or replacing the writte record with machine-generated records. Coloring all

the development was the ever-present reality that the cost of the system had to be kept under the $10,000 that was available for the project.

SYSTEM INPUT

Perhaps the most difficult problem was to develop a way of briefly describing a patient at the time of his initial evaluation so as to be able later to measure the treatment outcome. Diagnosis alone was felt to be insufficient, since in many cases it did not adequately describe the patient's reason for seeking help and his source of discomfort. Many things could cause someone with the diagnosis of schizophrenia to seek help, and although upon completion of treatment the diagnosis might still be appropriate, the patient's situation might have improved considerably. Diagnostic evaluation was therefore coupled with Weed's concept of the problem list (9).

Over a period of six months each staff member recorded the presenting problems of each patient seen. At the end of the six-month period the problems generated from all divisions within the department were reviewed. By combining similar problems, a standardized 72-item problem list was created. One category, "Other," was included with a space for narrative description. The items entered in this category can be periodically checked and the list revised in light of current clinical practice. In general, the list excludes diagnostic entities. However, problems such as depression, which at times are symptoms and not diagnoses, are included (see appendix 1).

A standardized list was necessary in order to permit retrieval of information and comparison of those data with other variables. The presenting problems of each patient as well as diagnostic impressions (up to three for a given patient) are recorded at the time of evaluation. The diagnoses are entered and stored as primary, secondary, or tertiary.

In addition to these data, a variety of other information is gathered during evaluation. Basic demographic data including social class (10) are recorded by the secretarial staff before the patient is seen for evaluation. The initial evaluator's discipline (social worker, psychiatrist, etc.) is specified, as are other treatment data. The evaluator is asked to specify the treatment to be used (drugs, individual psychotherapy, etc.), the proposed duration of that treatment (i.e., the number of visits), time spent on the initial evaluation, and other agencies or individuals who might be involved in the treatment.

This form is the first part of a two-part input system. The second portion is completed at the time treatment is terminated. The termination form, which is brief, gathers information about the treatment and its outcome.[1] The discipline of the final therapist is also recorded. Comparison of the disciplines of the initial evaluator and the final therapist allows a determination of how often one member of the interdisciplinary team refers a patient to another.

Other data recorded include the actual number of visits, method or methods of treatment used, specific names of any medications prescribed, final diagnosis, which when compared to the initial diagnosis allows some measure of diagnostic accuracy and consistency, initiator of the termination (patient, therapist, etc.), and a statement of outcome. The outcome judgment is made subjectively by the therapist on a five-point scale ranging from "much improved" to "much worse." It is made separately on two different features of the case. First, a statement concerning outcome for the patient's presenting problems only is made, and second, an evaluation of the patient's more global diagnostic condition is recorded.

Both the initial evaluation information and the termination outcome information are stored on a disc and entered by means of a keyboard-equipped cathode ray terminal connected to an IBM 370/155 computer. Information is entered directly into the computer through typewriter keyboard manipulation of a marker moving across the television image of the form being entered. The data are filed by hospital number, and each new patient creates a new file. Once the information from the initial evaluation form is entered into the computer, the form itself becomes the face sheet for the patient's clinical file. In this way the data are made immediately available to the therapist without our having to develop the costly capability of immediate communication with the computer. Similarly, at termination of treatment that form is filed in the patient's chart so that all data are available if the case should again become active.

SYSTEM OUTPUT

Two different types of outputs are routinely available. One is a report by divisions within the department. Each month, each division receives a summary of its data for that month and for the year to date. In addition, a total output for the department is generated. This report is simply a numerical summary of the items entered in the system. This relatively simple report allows comparisons among departmental divisions. It supplies data useful in planning program expansion, deployment of personnel, effort expended in a variety of different therapeutic modalities, description of the patient population, etc. It does not, however, furnish the data necessary for evaluation and comparison of the effectiveness of various treatment modalities, professions, etc. A more complex report is therefore required to meet other goals of the system.

The output most helpful for this review and evaluation is generated upon request for a given time period. A list of 72 standard multidimensional comparison programs is available.[2] Others can be specially programmed as needed. It is possible through these comparisons to satisfy all of the original goals of the system as well as many others. For example, program 49 ("Complaint—Psychiatric Service—Initial Diagnosis—Final Diagnosis—Proposed Visits—Actual Visits") allows a variety of com-

[1]The forms are available from the senior author on request.

[2]The list is available from the senior author on request.

parisons. This program allows a differentiation of diagnostic groups into smaller groups based on the patient's presenting complaint. It is then possible to compare the number of visits required by patients in these diagnostic subgroups. Furthermore, it is possible to compare the performance of the different divisions within the department. This can be done in relation to the divisions' expectations (proposed visits) as well as to their actual process (actual visits). If differences are found, other comparisons can be made to help isolate factors influencing the observed differences. If no differences exist, then a standard of practice within the department becomes evident.

DISCUSSION

The total system has been in operation since January 1972, although its development took approximately one year. As of April 1974, 4,660 patients were included in the file. The developmental costs of this system were kept under $10,000. This relatively low initial cost is matched by an equally reasonable annual maintenance cost. At present, all desired reports as well as minor program changes and additions are provided at a cost of less than $5,000 per year.

The system has already aided patients and staff in a variety of ways. Because of the evaluation data available, we are attempting new approaches to patients whose problems have not been resolved. For example, we found that we were seeing a large number of young women with the presenting complaint of depression. Therapeutic efforts with this group failed to produce a level of success with which we were satisfied. We are therefore currently in the process of establishing a group program designed to determine whether a feminist approach to this population (i.e., independence versus dependence, mastery versus powerlessness) will be more effective than a more traditional approach. Our standardized problem list has aided us in defining the actual stresses that cause people with given diagnoses to seek help. In this process the variability of initial diagnostic impressions versus final diagnosis has become obvious.

Some divisions in the department are funded by outside sources. We have satisfied the funding bodies' questions, and this has resulted in continued and increased support. A satellite clinic has been established in an area identified by the system as containing a high proportion of our patients. The list of standard multidimensional programs enables us to calculate average utilization of service, defined not just by diagnosis but also by other variables such as problems, outcome, and therapist.

Despite the benefits, problems do exist in the system. Perhaps the major problem is using the therapist's subjective impression to rate treatment outcome. A "harder" measure of treatment outcome would be far more desirable, but it would also increase the cost of the system by increasing demands on professional time, computer time, and programming time. In practice, we have found that the major error made in rating a patient is for the therapist to be harder on himself than other members of the treatment team would be.

Another problem we had anticipated was that the standardized problem list would be incomplete, despite the six-month preparation time. In fact, we have found it to be about 90 percent complete. The list is about to be changed to delete items not used and to add items that were originally omitted. This is possible since we have stored in narrative form all problems listed in the "Other" category on the evaluation form.

In conclusion, this multifunctional, low-cost system is capable of meeting current review standards and of generating information that can make those standards realistic and patient oriented rather than solely cost oriented.

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APPENDIX 1

Patient's Presenting-Complaint List

Abortion
Aggressive, out-of-control behavior
Anxious
Child abuse
Conflict with boyfriend/girlfriend
Conflict with governmental authority
Conflict with parent
Conflict with sibling
Conflict with spouse—marital problems
Death in family
Delusions
Depressed
Disorientation in person
Disorientation in place
Disorientation in time
Disrupted family (separation, divorce)
Disturbing fears
Drinking problem

Drug abuse
Employment problems
Fear of child abuse
Feeding problem
Financial problems
Grief reaction
Hallucinations
Head banging
Hearing problem
Homicidal attempt
Homicidal thoughts
Hyperactivity
Inadequate housing
Learning problem
Masturbation
Memory disturbance
Menstrual problem
Mental illness in family
Movement disorder
Nonorganic somatic symptoms coexisting with organic disease
Physical illness in family
Physical illness in self
Postoperative reaction
Pregnancy problems
Preoperative reaction
Problem in peer relationships
Problems with child
Problems with the law
Religious conflict
Repeated emergency room visits
Repeated hospitalizations
Rocking
School behavioral problems
Separation problem
Sexual, out-of-control behavior
Sexual problems
Social isolation
Somatic symptoms—no organic disease
  A. Dizziness
  B. Palpitations
  C. Headache
  D. Fainting
  E. Trembling hands
  F. Perspiring hands
  G. Respiratory irregularities
  H. Pain
  I. Numbness
  J. Other
Speech problem
Suicidal thoughts
Suicide attempt
Tantrums
Thumb sucking
Toileting problem
Trouble sleeping
Other (specify)

Ethical Issues in Family Planning for Hospitalized Psychiatric Patients

BY HENRY GRUNEBAUM, M.D., AND VIRGINIA ABERNETHY, PH.D.

The authors present guidelines based on their experience with a family planning program for patients in mental hospitals. They believe that informed consent for these patients should include an adequate knowledge base, the patients' competence to make decisions, and the absence of coercion. Among safeguards are the reversibility of contraceptive procedures, the separation of the family planning counselor from the treatment staff to avoid possible covert coercion, and careful choice of the stage of hospitalization at which counseling occurs. The authors examine the implications of a patient's refusal to use contraception, noting the impossibility of involuntary contraception and the ethical and legal problems regarding sterilization procedures.

PREVIOUS PUBLICATIONS by ourselves (1–3) and by others (4–6) have documented both the need to make family planning assistance available to patients in psychiatric institutions and patient receptivity to such programs. This paper deals with ethical issues encountered during two years of research and development related to the operationalization of a service that provides birth control and gynecological care in three state mental hospitals.

While some believe that family planning and contraception are inherently unethical, our program is based on our conviction that the individual has a right to control his or her own fertility. We will explore the problems that occur in the exercise of this right for mentally ill individuals. In each instance, we must take into account the rights of the patient, the unwanted child she may bear, and the larger society—rights that often appear to conflict. In addition, we will consider the relationship between the patient and the treatment staff of the mental hospital.

From the patient's point of view, particularly in terms of her civil rights, what is necessary is her informed consent. This involves three major factors: 1) adequate knowledge on which to base a decision, 2) competence to make a decision, and 3) absence of coercion in the decision-making process. Since the main purpose of a family planning program is provision of adequate information about the various contraceptive methods available, this aspect of informed consent does not present much of a problem in our program. However, competence to make such a decision becomes an important issue when the individual is mentally ill and her judgment and reasoning may be impaired. Finally, the mental hospital or clinic setting can be perceived as overtly or covertly coercive. We shall therefore focus our attention on the issues of competence and coercion.

It should be noted that the patient's civil rights and informed consent are not the only ethical values which must be considered. Her physical and mental health are also important. Society, for instance, is prepared to compromise civil rights when individuals undertake acts that will impair their own welfare too severely, such as self-mutilation or suicide attempts.

The benefits of contraception are obvious, and all known contraceptive procedures except sterilization (which our program does not provide) are reversible. Thus, a contraception decision made by a patient is not irrevocable. This fact may ameliorate the problems of competency and coercion (in ethical if not in legal terms), since the patient can reverse her decision at a later date.

SAFEGUARDS FOR PATIENTS IN MENTAL HOSPITALS

In order to give informed consent, a patient must have the capacity to make a sound judgment and must agree of her own free will to use contraception, knowing its risks and effects. For this reason, we will exclude from our discussion those instances when a decision is made by a guardian or parent for the patient and those in which a spouse or partner assumes responsibility for family planning.

In order to ensure that the patient has given informed and voluntary consent, we have confined our services to patients who are not acutely psychotic or confused. As patients improve from an acute decompensation, they become able to take care of themselves, resume their usual responsibilities, and spend increasing amounts of time outside the confines of the hospital. We do work with chronically psychotic women, taking into account the limitations inherent in their residual disability. We provide contraception only when the patient's psychiatrist gives permission, since the psychiatrist is in a good position to know whether she is capable of providing meaningful informed consent.

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Avoiding Coercion

Most patients today are admitted to Massachusetts mental hospitals voluntarily; few are involuntarily committed. If the hospital staff and family planning services exert no coercion on the patient, and if discharge, privileges, and other rewards are explicitly not made contingent on the use of contraception, consent can be considered to have been freely given. However, the subtle pressure of the hospital on even a voluntarily admitted patient is not to be underestimated. Even when no coercive intent exists on the part of the staff, patients may feel that they "have to do what the doctor says" if they are to receive his care and concern. Patients in state mental hospitals are dependent and, in many ways, powerless. In addition to the disadvantages inherent in mental illness, they often have additional disadvantages related to low economic position and lack of education. The stigma of the mental illness label also reduces their power. Mental patients are not in a position to "talk back"; they may not see themselves as free to refuse or withdraw from participation in family planning counseling. Because the counselor has the trappings of authority, it is not unusual for a patient to agree overtly, while evidencing covert disagreement by her behavior. Thus, the critical issue for the hospital staff is to avoid using its position coercively. One method we have employed is differentiating the family planning counselor from the treatment staff. In our program, the nurse-counselor plays no therapeutic role outside the area of family planning.

Reversibility

A second safeguard for the patient is the fact that all of the contraceptive methods we employ are reversible. We believe it is crucial that mental hospitals not offer sterilization or vasectomy to their patients. Patients who desire these services can be referred to an outside agency, but the hospital should play no role in promoting these nonreversible decisions.

Choosing the Proper Time

A third safeguard is to provide services for the patient at a time in her hospitalization when it is most probable that she can make a reasoned decision; i.e., when she is assuming increasing responsibility for the rest of her life, particularly her sexual relations. It would be paradoxical to permit a patient to decide to have sexual relations on an overnight or weekend pass and not permit her to decide to use contraception. Custodial hospitalization regulated patients' sexuality to a great extent; in community-based treatment, our attention must focus on patients' fertility.

THREE "COMPOSITE" PATIENTS

In order to focus our discussion, we shall describe three "composite" mental patients who exemplify the kinds of problems we regularly encounter in family planning counseling. The first patient is Miss Acute, a 17-year-old from a large poor family who made a suicidal threat when her boyfriend left her. She has had rather promiscuous and unprotected sexual relations and probably will continue to do so after her hospitalization, which will most likely be brief. The second patient is Mrs. Recurrent, age 35, who is married and has four children, the last of whom was clearly unwanted. She was admitted recently for her third hospitalization in a depressed and confused state. The third composite is Miss Chronic, age 32, who has been in and out of mental hospitals for 10 years. She occasionally works as a waitress and at other times is on welfare. Two of her four pregnancies were terminated by abortions; one of the two children she has borne is being reared by a sister, and the other was given up for adoption.

In our experience, it is likely that Miss Acute and Mrs. Recurrent will choose to use contraception. However, a closer look suggests that their complex situations are not so quickly resolved. Miss Acute may try to use the pill, but she may forget to take it regularly, perhaps in an unconscious or deliberate attempt to force her boyfriend to marry her. She may be motivated by her need to provide her mother with a child; she may seek to mother a child who is unconsciously seen as a mother to her; or she may act on the basis of a generalized self-destructive drive. Mrs. Recurrent will attempt to use an intrauterine device for a variety of possible reasons: e.g., pressure from her husband, who wants to discontinue using condoms, or awareness of her own ambivalence about using contraception regularly.

While the family planning counselor may believe that Miss Acute is acting in an ill-advised way and that Mrs. Recurrent is making her decision under pressure from her husband, their behaviors are both understandable and typical. Both of these women can give informed consent to the use of contraception, and only rarely will the mental health professional feel that such consent is unreasonable. The problem for the staff arises when a patient refuses contraception or is not adequately informed as to its risks.

Issues When the Patient Chooses Contraception

It is sometimes difficult to ensure that psychologically disturbed individuals fully understand the risks and complications of various contraceptive procedures—meticulous efforts are required. The issue is complicated by the fact that some patients do not want to know about the risks of contraception, just as medical patients often do not wish to hear about all the risks of an operation or the prognosis of an illness. This places the counselor in the difficult position of having to decide between the patient's chosen stance and informing her adequately. We believe that patients who are aware that there are risks involved in contraception but who make it clear that they do not wish to be burdened with the details of these risks have the right not to know.

The ethical issues raised when a patient consents to contraception include the questions of whether she: 1) is adequately informed about the risks and complications of the specific contraceptive she is using, 2) is competent,

and 3) gives her consent freely. There are no ethical issues relating to unconceived children and no societal responsibility for a child who might become a social burden. There is, however, the social need to ensure that individual liberty has been preserved and that the staff of the mental hospital has not used its position coercively. Mental patients (particularly those who are committed) lose certain freedoms, and all mental hospitals are inherently coercive to some extent, which tends to deprive their patients of choice.

Issues When the Patient Refuses Contraception

Although informed consent poses problems and requires safeguards, the major ethical dilemma in family planning for mental patients arises when the patient decides not to use contraception and, like Miss Chronic, has a history indicating that she is likely to become pregnant. Miss Chronic is capable of living outside the hospital at times and of having sexual relations, but her ability to mother a child is impaired. Another pregnancy may be disadvantageous for all involved. Even if the patient wants to become pregnant, those responsible for her care may not believe this to be in her best interest, since her hospitalizations are precipitated by pregnancies and mothering an additional child would be an unnecessary, stressful burden. Her child might have a greater than normal genetic predisposition toward psychopathology. In addition, he would either be reared by a mentally ill mother or given up for adoption or foster care, neither of which is optimal for his future adjustment. And finally, society would probably have to assume some of the financial and social burdens in this situation. The hospital staff, as the representatives of society, have direct responsibility for the welfare of the patient, and they may be reluctant to discharge her. They may fear she will be "taken advantage of," and continual hospitalization may therefore be used as a means of contraception. For all these reasons, the incentive of the counselor to act coercively and insist on contraception is powerful.

CONTENT OF COUNSELING

What is to be done about the problem of patients like Miss Chronic? One approach is to reevaluate the information that is provided to the patient regarding her situation. Complete information for consent purposes could include reminding the patient of a pattern in her past in which recurrences of her illness were associated with pregnancy. It could be indicated that she might find additional children too great a burden. This may not be necessary, particularly if her husband or partner is making efforts to ensure that she will not become pregnant. The problem is greater when the partner is casual or unconcerned with the woman's long-term well-being.

Genetic Risk

In addition to these patient- and partner-oriented aspects of information, there are two other issues that might be discussed in counseling. The first concerns the genetic risk to the child. Adequate genetic counseling should be part of a person's knowledge base in an informed decision. Clearly, if there was a history of genetic disease, such as hemophilia or Huntington's chorea, this information would be given to the patient. Such information should be given even when the risk of transmission is far less. (In all likelihood a patient would already know about such a problem.) The inheritance of mental illness is less clearly understood, but it now appears that what is probably transmitted is a tendency toward psychopathology, with the final outcome uncertain. It seems, however, that the children of parents with chronic or process schizophrenia are at some genetic risk. It is vital to note that while carriers of very serious genetically transmitted diseases may be discouraged from having children, society in no way prevents them from doing so, even though society bears some of the financial costs of their children's disabilities. Society took a totally different position concerning mental disabilities in the involuntary sterilization laws for the "insane" and "feebleminded." These statutes, while still on the books, were not utilized very often and are now used even less.

For the reasons we have described, it seemed to us that a discussion of genetic risk might be appropriate in family planning counseling, at least for mental patients with a diagnosis of chronic schizophrenia. Indeed, to avoid this issue might be to collude in the patient's denial of this risk and concern. However, this approach has been unproductive and has had little impact on the patients with whom it has been attempted because they lack the interest or sophistication to comprehend it. We have abandoned discussion of genetic risk unless the patient brings it up, which does happen with less disturbed women.

Environmental Risk

Discussing environmental risk with the patient may at first appear more problematic than discussions of genetic risk. The evidence for purely environmental disadvantage to children of mentally ill mothers is less clear-cut: the studies to date are of children who have been reared by their own parents, which confounds the influence of nature and nurture. These studies suggest that having a psychotic parent is associated with some disadvantages for the child, but they do not point to any clear-cut or inevitable result, particularly since the potential ameliorative influence of the other parent is an important factor.

We are unwilling to predict that a particular patient will be a poor mother, given our current knowledge and the possible detrimental impact of such a statement on a patient. However, we do find it very useful to ask and discuss with the patient such questions as, "What kind of a mother do you think you could be now?" These are questions most patients are already considering seriously, and they will often open up important, if painful, dilemmas. Some of the more seriously ill patients we have counseled deny that they have any concerns about their mothering capacity and refuse to discuss the issue. The child is seen as a plaything or possession. Often these women have had pregnancies terminated by abortions or have had children removed from their care by the state. We believe that it is

appropriate to discuss any such history with the patient. If the state has regarded her as an unfit mother in the past, then it may do so again in the future, given a similar pattern of maternal behavior. The problem for the mental health professional is that those facts which make it clear that contraception is appropriate are the most difficult ones to discuss with the patient, since they also may imply that she will be a "bad mother." Such discussions may also be perceived as coercive by the professional, i.e., they use facts to force a certain outcome. Environmental risk is thus one of the most difficult matters to discuss frankly.

Even when all the facts are presented clearly to the patient, there will be a certain number of instances in which contraception is refused and in which the mental health professional feels that a pregnancy is not in anyone's best interests: the patient's mental and/or physical health may be endangered, her child may be subject to genetic or environmental risk and in many cases should or will be removed from her care, and society may have to assume the burden of support for the child.

STERILIZATION AND OTHER ISSUES

For a variety of reasons, nothing can be done with regard to contraception in situations where a pregnancy seems most inadvisable and contraception is refused. It is a fact that all current methods of contraception are reversible: we have even seen psychotic women who have pulled out their IUDs. It therefore makes no sense to attempt to force patients to use contraception.

The situation may be otherwise with regard to sterilization. It has been suggested that the judicial determination of incompetency and the provision of a guardian may well be the most effective way to safeguard the patient's rights. However, we have not been impressed by the experience with judicial intervention in sterilization, and the inconvenience of the procedure has led to its being used infrequently. Beyond this, it is our experience that judicial hearings on mental health matters tend to be rubber stamps for the hospital. We have observed that members of these judicial boards are rarely the most competent members of the profession and, as is often the case with such bodies, their ties are more with their colleagues than those whose rights they should protect. In such hearings, the rights of minorities, the poor, and the uneducated are sometimes neglected.

Regardless of the decision about sterilization, it is clear that involuntary contraception is simply not possible. Pills can be thrown away, an IUD can be removed, and a patient need not return for her injection of progesterone.

GUIDELINES FOR COUNSELING

The position that we have finally evolved may be summarized in the following manner. To make an informed decision, the patient must have a careful and painstaking discussion with the family planning counselor of the risks and gains involved in whatever course she selects. The effects of various contraceptive methods must be explained and the risks to her and to her future children should be broached. The feelings of the patient should be elicited first, since concern about the ability to bear children and about one's effect on one's child are life-long issues for all parents.

It may be appropriate to indicate to patients that there is a tendency for mental illness to be inherited. Patients know that "the apple does not fall far from the tree." Similarly, it is important to consider with the patient her ability to care for a child at this particular time in her life. An appropriate approach might be, "Is this the time for you to have a [or another] child?" If previous pregnancies have been terminated by abortion or a patient's children have become wards of the state, these facts should be part of the information discussed to obtain informed consent. As we have noted, involuntary contraception is not possible and will probably not become so until and unless resource scarcity makes it necessary. Whether sterilization is the ethically appropriate next step is a matter for separate consideration.

CONSIDERATIONS FOR THE FUTURE

Difficult as they have been to formulate, the guidelines we have presented barely suffice for the present and may be called into question if resources become scarcer and therefore more expensive, with an ensuing fall in the standard of living for the majority of citizens. At this time, we fully anticipate increasingly widespread pressure for, and practice of, unregulated procedures. For example, the newspapers recently reported the sterilization of two retarded black adolescents, apparently without the informed consent of themselves or their families.

We feel that such unregulated procedures have dangers both for the individual whose civil liberties may be deprived and for the future of programs providing birth control resources to the mentally ill or retarded, which might be terminated due to extreme negative reactions. Therefore we urge continuing consideration that takes as its point of departure the logical distinction which can be made between the right to sexuality and the right to fertility. It seems to us that the "right" to procreate may be fairly questioned when there is high genetic or environmental risk of mental disability and when the prospective parents are unable to care for or adequately support children. Inevitably, one confronts the philosophical and pragmatic questions of whether there should be (or, on a continuing basis, can be) rights without responsibilities and how this issue can be adjudicated in a fair and humane manner.

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Workshop on Writing for Scientific Journals

The 1975 annual meeting of the American Psychiatric Association will feature the seond annual workshop on writing for scientific journals, to be held from 9 a.m. to 5 p.m. on Sunday, May 4 (the day before the annual meeting begins). The workshop, cosponsored by APA and the American Medical Writers Association (AMWA), will offer practical information and instruction on four subjects: common writing faults, organizing medical reports, getting your words on paper, and submitting a manuscript. Work assignments, which will be sent to registrants before the meeting, will form the basis for initial discussions during the workshop sessions. The course will begin with brief introductory lectures by the AMWA faculty, who include Charles G. Roland, M.D., chairman of the Department of Biomedical Communications, the Mayo Foundation; Barbara G. Cox, medical writer, Instructional Development Section, the Mayo Foundation; and Martha Tacker, Ph.D., free-lance medical writer and editor. Following the lectures there will be small-group discussions on the four basic subjects. The workshop will conclude with a panel discussion in which participants will have the opportunity to question the editors of several psychiatric journals.

Registration is limited to 40 participants. All applications for participation must be received by April 7; the registration fee is $65. For further information on registration write to Charles G. Roland, M.D., Department of Biomedical Communications, the Mayo Foundation, Rochester, Minn. 55901.

One-Year Follow-Up of Hyperactive Boys Treated with Imipramine or Methylphenidate

BY PATRICIA O. QUINN, M.D., AND JUDITH L. RAPOPORT, M.D.

The authors report on a one-year follow-up of 76 hyperactive boys who had participated in a comparative study of methylphenidate, imipramine, and placebo. They found that there was a higher rate of discontinuance of imipramine than of methylphenidate in this sample and that both medications decreased the boys' rate of weight gain but had no significant effect on growth in height. This finding is of concern because larger doses than were used in this study are in use elsewhere. Teachers reported that the group of boys who had discontinued either medication showed continued hyperactivity and behavior problems in the classroom at one year. The two treatment groups showed continued improvement at one year in classroom and home behavior and did not differ significantly from each other.

THE STIMULANTS amphetamine and methylphenidate reduce restless and negativistic behavior in comparison with placebo in 70 to 80 percent of hyperactive children treated for 6 to 12 weeks (1). The fact that these drugs wear off rapidly and the finding (2, 3) that they have such side effects as anorexia, weight loss, and growth disturbances have caused clinicians to seek alternative agents to treat hyperactive children.

The tricyclic antidepressant imipramine was found useful first in treating childhood enuresis (4) and later in treating behavior and learning problems in children (5, 6). Minimal side effects occurred with doses of 25 to 75 mg a day. Higher doses of imipramine have also been used with some short-term success (7, 8) in treating school phobia and hyperkinesis. However, serious side effects have been reported (9, 10), and few long-term treatment data are available.

A recent study of 19 outpatient hyperactive boys (11) showed 174 mg of imipramine a day to be effective during an 8-week treatment period. However, 78 percent of this sample suffered weight loss. In a comparative double-blind study conducted for 6 weeks at our clinic (12), imipramine was found to be superior to placebo but less effective than methylphenidate, particularly for cognitive test measures. Weight loss occurred even though only 80 mg of imipramine a day was administered.

Because of the lack of information about long-term drug treatment of hyperactivity, we followed up the 76 patients who participated in the comparative study of methylphenidate, imipramine, and placebo (12). We were particularly interested in the growth of children remaining on the drugs, the long-term pattern of use of medication, and the behavior effect of continued drug treatment.

Ideally, randomly assigned placebo and drug-treatment groups should be available for long-term comparison, but such groups are ethically and logistically difficult to obtain. We therefore report data on the follow-up "drug history" for the sample as a whole and for two groups who continued their original randomly assigned medication (imipramine or methylphenidate). We included a comparison group in which medication was discontinued after 4 months or less in spite of an initial good response to medication as judged from the blind 6-week trial or a trial that was not blind following administration of placebo.

We believe that the methodological impurities of such a comparison are outweighed by the need for long-term follow-up reports. In addition, standardized tests, rating scales, and normative data make a comparative assessment of our populations possible and facilitate communication among treatment centers.

METHOD

The 76 patients who participated in the initial comparison of methylphenidate, imipramine, and placebo (12) were seen for 6 weeks during their initial drug trial. At the end of this period, the placebo group was assigned randomly to one of the two drug groups and another 6-week trial that was not blind was conducted. Drug management was then continued during the year by the family pediatrician in consultation with the Hyperactivity Clinic. The patients in the active drug groups were continued on their initial drug whenever possible.

Seventy-three (96 percent) of the children were seen with their parents for a follow-up evaluation after one year. Two of the families had moved, but they provided behavioral data through mail and phone contact. One family withdrew from the study. Height and weight measurements were made on all of the children by the same examining pediatrician (P.O.Q.) at the same time

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of day and on the same scale used at the initial visit. A history of medication use during the year was obtained.

Parents completed the Conners Parent Symptom Questionnaire (PSQ) (13); teachers completed the Conners Teacher Rating Scale (TRS) (14). These scales contain 39 and 92 behavioral items, respectively, which are given weighted scores from 0 (not at all) to 3 (very much). Individual factors for conduct disorder and hyperactivity have been identified. A battery of psychological tests was repeated, including the Wechsler Intelligence Scale for Children (WISC), the Wide Range Achievement Test (WRAT), the Porteus Maze Test, and our own global clinical rating on a 6-point bipolar scale.

Patients were urged to continue initial active medication when possible; changes were made only when they were judged clinically necessary because of home or school pressure. Thus optimal clinical maintenance was continued by the family pediatrician throughout the year. Both imipramine and methylphenidate are used in our area; we are unaware of any general bias in favor of either by participating physicians.

RESULTS

Continuation of Medication

At one year, 23 of the 29 boys in the initial methylphenidate group (79 percent) had remained on that medication. Their mean daily dose was 20.65 mg ±8.56. Of 9 boys who were randomly assigned to methylphenidate after a 6-week placebo trial, 6 had continued on that medication until the one-year evaluation. Thus 9 boys out of 38 had discontinued methylphenidate during the year (2 for irritability and excitation, 5 for worsening behavior, and 2 because of parental disapproval of medication).

Thirteen of the 29 boys in the initial imipramine group (44 percent) had continued on imipramine for 12 months. Their mean daily dose was 65.4 mg ±19.2. Of 8 boys randomly assigned to imipramine after a 6-week placebo trial, 5 continued on that medication for the remainder of the year. Thus a total of 19 out of 37 had discontinued imipramine after an initial trial (7 for unchanged behavior, 3 for hypertension, 7 for irritability and temper tantrums, and 2 because of parental disapproval of medication).

We were interested in both growth and behavioral changes at one year in relation to drug treatment. While 75 of the initial patient group had been on some medication during the year, growth and behavioral changes were compared only for children initially assigned to the active drug group and continued on the same medication for one year (23 on methylphenidate and 13 on imipramine) and for a comparison group of 12 hyperactive children who had shown some clinical response to the drugs but had discontinued treatment because of parental concern over side effects or over continued drug use.[1]

[1]An earlier estimate of drug treatment status at 6 months (12) proved erroneous at one-year follow-up. More children had discontinued medication at one year than was known at 6 months.

Side Effects and Growth Change

For the children who continued to take medication, anorexia was the most frequently noted side effect (39 percent and 47 percent of imipramine and methylphenidate groups, respectively). However, occasional complaints of irritability (3 patients receiving imipramine) and overstimulation (2 patients receiving methylphenidate) were noted. No seizures were reported.

Height and weight measurements were converted to percentile scores based on age and sex for a normal population (15). These are shown in table 1. The 23 children on methylphenidate for 12 months lost about 8.8 percentile points in weight and gained about 3.2 percentile points in height. The 12 children on imipramine lost about 7.6 percentile points in weight and lost about 2.2 percentile points in height. The 12 children who had discontinued treatment within 4 months gained about 1.6 points in weight and lost about 1.5 points in height.

The methylphenidate group who received a daily dose greater than 20 mg showed a 15.4-point weight loss and a 3.0-point height decrease, compared with a 6.9-point weight loss and a 5.1-point height gain for the group taking 20 mg or less of methylphenidate daily ($t=2.36$, $p<.02$ for weight by Student's t test).

Statistical comparisons between drug groups and the untreated group are also shown in table 1. Both drug treatment groups had a significant decrease in growth rate for weight but not for height when compared with the group who had discontinued medication.

Behavioral Change

The striking clinical impression at one-year follow-up was that the boys in all three groups continued to have difficulties. Few children were considered symptom free, although 24 (31 percent) of the entire sample appeared improved or much improved. Few had sought other treatments; 3 families were counseled briefly for behavior management, and 3 children had been placed in special educational settings.

Of the 29 children who had tried either imipramine or methylphenidate and then discontinued medication, 12 were selected for a comparison group because they had discontinued medication within 4 months and had not resumed it and because they had shown some behavioral improvement with medication on an initial blind trial or subsequent trials that were not blind. The reasons for discontinuation of the drug were: parental disapproval (3 patients), hypertension (3 patients), and irritability (6 patients).

The behavior ratings of teachers and parents at baseline, at 6 weeks, and at one-year follow-up are shown in table 2 for the two treatment groups. Baseline and one-year follow-up ratings are given for those who discontinued medication.

The three groups did not differ significantly on baseline measures. The TRS factor IV, hyperactivity, tended to be lower for the imipramine group than for the others. The baseline scores for the 16 children from the original randomly assigned group who discontinued imipramine were

TABLE 1

Percentile Scores for Growth Change for Three Groups of Hyperactive Boys at One-Year Follow-Up and Group Comparisons by Student's t Test

Treatment Group	Weight Change						Height Change					
	Mean Score	SD	Comparison with Imipramine Group		Comparison with Untreated Group		Mean Score	SD	Comparison with Imipramine Group		Comparison with Untreated Group	
			t	df	t	df			t	df	t	df
Imipramine (N=12)	−7.54	11.31	—	—	2.45*	22	−2.20	4.77	—	—	.23	22
Methylphenidate												
All doses (N=23)	−8.81	7.93	.37	24	3.42**	33	+3.19	14.02	1.25	24	1.05	33
More than 20 mg a day (N=5)	−15.40	9.65	1.27	15	4.18**	15	−3.00	18.90	.12	15	.22	15
20 mg a day or less (N=18)	−6.88	6.46	.19	28	3.44**	28	+5.12	12.25	1.90***	28	1.59	28
No treatment (N=12)	+1.61	5.72	—	—	—	—	−1.46	8.39	—	—	—	—

*p<.01.
**p<.005.
***p<.05.

TABLE 2

Teacher (TRS) and Parent (PSQ) Behavior Ratings of Three Groups of Hyperactive Boys at Baseline, at Six Weeks, and at One-Year Follow-Up

Treatment Group	Behavior Ratings					
	Baseline		Six Weeks		One Year	
	Mean	SD	Mean	SD	Mean	SD
Imipramine (N=13)*						
TRS factors						
Conduct (I)	11.92	9.30	3.46	3.28	5.61	6.02
Hyperactivity (IV)	11.30	5.48	5.76	2.55	8.07	5.12
PSQ factors						
Conduct (I)	10.23	5.56	6.07	5.02	7.61	4.03
Anxiety (II)	4.84	3.26	2.92	2.78	3.46	2.60
Hyperactivity (III)	12.53	3.45	5.23	3.60	6.76	3.74
Methylphenidate (N=23)**						
TRS factors						
Conduct (I)	12.60	10.56	7.52	8.51	7.34	7.17
Hyperactivity (IV)	13.78	4.03	6.69	4.32	8.30	4.66
PSQ factors						
Conduct (I)	8.62	5.03	5.69	3.73	6.47	4.34
Anxiety (II)	4.60	3.17	2.73	2.31	3.60	3.31
Hyperactivity (III)	12.73	5.36	5.54	4.83	6.69	3.59
No treatment (N=12)***						
TRS factors						
Conduct (I)	12.50	7.21	—	—	12.16	8.88
Hyperactivity (IV)	13.00	3.86	—	—	11.33	4.55
PSQ factors						
Conduct (I)	10.50	4.14	—	—	6.75	4.00
Anxiety (II)	4.08	2.71	—	—	2.16	2.47
Hyperactivity (III)	14.16	4.42	—	—	7.75	6.25

*Mean age for this group was 9.38±1.55.
**Mean age for this group was 8.91±1.61.
***Mean age for this group was 9.09±2.02.

somewhat higher than scores of children remaining on imipramine, although not significantly so (t=1.40 by Student's t test).

At one year the groups did not differ on the parent ratings: all three groups were rated by parents as having a highly significant decrease in hyperactive and distractible behavior compared with their behavior at baseline. The untreated group, however, did not change significantly in teacher-rated classroom behavior, while the two treatment groups did. The two treatment groups were similar to each other in their one-year follow-up behavioral classroom ratings, as shown in table 3.

Psychological Testing

Scores on the WISC, WRAT standard scores, and Porteus Maze Tests did not differ at baseline or at one

TABLE 3
Comparison of Teacher (TRS) and Parent (PSQ) Behavior Ratings for Three Groups of Hyperactive Boys

	Comparison of Treatment Groups, by Student's t Test					
	No Treatment Versus Methylphenidate*		No Treatment Versus Imipramine**		Methylphenidate Versus Imipramine***	
Rating Scale Factor	t	Significance	t	Significance	t	Significance
TRS factors						
Conduct (I)	1.68	p<.05	2.08	p<.02	.71	n.s.
Hyperactivity (IV)	1.79	p<.05	1.60	p<.10	.13	n.s.
PSQ factors						
Conduct (I)	.18	n.s.	.51	n.s.	-.76	n.s.
Anxiety (II)	1.28	n.s.	1.23	n.s.	.12	n.s.
Hyperactivity (III)	.62	n.s.	.46	n.s.	-.05	n.s.

*df=33.
**df=23.
***df=34.

year between the groups. Individual behavioral change did not correlate with changes on any of these tests for any group.

DISCUSSION

Both imipramine and methylphenidate were found to decrease the rate of weight gain for children receiving medication for 12 consecutive months compared with a treatment dropout group. This replicates previous reports for methylphenidate at doses above 20 mg (2, 3). Our finding of decreased weight gain with lower doses of methylphenidate may reflect the facts that our sample had not discontinued medication during the summer months and that most received medication in divided doses.

The decrease in weight gain with imipramine was surprising in light of the fact that the mean daily dose given our patients was smaller than that in use elsewhere. Although there was no height decrease with either drug, the children had received medication for only one year. Decrease in growth rate has been found in children who have received drugs for two or more years. The rate of growth should therefore be examined carefully for children receiving higher doses of imipramine for longer periods of time. The significant decrease in height for imipramine compared with low doses of methylphenidate is probably the result of sampling variation; this did not occur when the imipramine group was compared with the untreated group.

Significantly more children ($\chi^2=7.30$, df=1, $p<.01$ by chi-square test) discontinued imipramine than methylphenidate in spite of the clinical bias to have them continue. This is in agreement with the pilot study reported by Gittelman-Klein (8) in which most children with initial short-term response to imipramine could not be maintained on it because of their deteriorating clinical course. Similarly, although Waizer and associates (11) reported the superiority of imipramine over placebo throughout an 8-week drug treatment period, they also found that the teachers' global improvement ratings during the latter part of the treatment period did not show sustained improvement. The basis for this discrepancy is not clear, but it is possible that it reflects a decline in overall clinical status with continued imipramine treatment.

Methylphenidate has been shown to differentially affect dopaminergic rather than adrenergic function (16), while imipramine has little effect on dopamine uptake (17). The more general efficacy of methylphenidate at one-year follow-up, particularly for the more aggressive children in our sample, lends some indirect support to the idea that dopaminergic mechanisms are involved in the impulsive aggressive behavior disorders of childhood.

Behavioral changes are the most difficult to evaluate from the present data. All three groups were seen as improved by the parents. This may reflect the parents' desire to see the children's ongoing treatment (or lack of it) as successful. On the other hand, it may indicate an actual decrease in difficulty at home.

The two treatment groups had significant and similar decreases in classroom ratings of hyperactivity and conduct disorder. The teachers were unaware that a comparative study was in progress and were not the same teachers who had made the baseline ratings the previous year. Their ratings may therefore have been subject to less bias than the parents' assessments. It is possible, however, that as the children mature their restless behavior decreases first in the home setting and continues longer in the more structured classroom setting. The good responders to imipramine and the good responders to methylphenidate did not differ in any measure at one-year follow-up.

These data supporting the long-term effect of medication on classroom behavior must be interpreted with caution because the control group of treatment dropouts may have biased the results. Adverse home or school influences as well as the constitutional endowment of the child might have been confounded with discontinuation of treatment. It was our clinical impression, however, that concern about drug use or side effects was the chief

reason for discontinuing medication for this group. They did not seem to differ in other respects from the two treated groups.

A strength of the present study is that almost all of the initial responders to stimulants were followed for one year; their course may be representative of larger populations.

It is also important to note that while classroom hyperactive behavior decreased relative to baseline values for the treatment groups, the classroom ratings of these groups were high in comparison with the norms available for their age group according to Sprague and associates (18). We are also impressed with the relation of classroom structure to the teachers' behavioral assessment and complaints; this will be reported on in another paper.

We hope that continued reporting of objective rating scale data will allow clinicians and researchers to compare the initial severity of patient samples as well as long-term response to treatment or treatment combinations.

While our long-term data favor the stimulant drug, good responders to imipramine showed similar clinical response to the stimulant. The advantages of imipramine, which does not have to be given during school and does not wear off rapidly, may be important in some settings. Thus for selected individuals imipramine may be a useful alternative to stimulant drugs.

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Personality and Behavior Patterns of Heroin-Dependent American Servicemen in Thailand

BY GEORGE KOJAK, JR., M.D., AND JOHN P. CANBY, M.D.

The authors compared a group of heroin-dependent American servicemen stationed in Thailand with a matched control group of men not dependent on heroin. The data gathered regarding social history, attitudes, work record, previous drug use, personality, and intelligence show significant differences between the heroin-dependent men and the control group in four areas: intelligence, work record, number of years of schooling, and number of drugs used before using heroin. The data suggest that many of the heroin-dependent men had difficulties related to a distant or negative relationship to their fathers; however, in contrast to previous studies of heroin addicts, they do not confirm a relationship between heroin dependence and any particular personality pattern.

SINCE THE UNITED STATES seems to be in the midst of a national epidemic of heroin abuse, it would be useful to have objective data regarding the heroin-dependent person's personality and behavior. Otherwise excellent studies have been limited because the only available subjects were long-term addicts who, in many cases, were from particular socioeconomic levels or geographic areas where social disintegration, crime, and poverty were given factors. The reported increase in prevalence of heroin addiction in a broad spectrum of social and geographic groups makes it desirable to investigate other populations in which heroin addiction has become more visible. A population of servicemen in areas where heroin is more easily available than it is in the United States would serve as such a population.

The population for our study encompassed members of the U.S. Army in Thailand and all military personnel in the Bangkok area. These men came from all geographic areas of the United States and from every social group. They were employed in a noncombat area and had a higher level of education than the average American man because of the nature of their jobs. In Thailand there were almost no practical difficulties in obtaining 98 percent pure heroin that was inexpensive.

All military personnel in Thailand submitted urinalyses several times a year. Anyone who appeared to be using opiates—by his behavior, by clinical examination, or by urinalysis—was evaluated by the Department of Psychiatry at the U.S. Army Hospital. A closely supervised staff working with small numbers of patients facilitated the cooperation of our subjects and the accuracy of data collection.

This report compares personality and behavior data obtained from the patient group with data obtained from a representative sample control group.

METHOD

Population Studied

The heroin-dependent group (N=25) was composed of men between the ages of 18 and 25 who had less than three years of military service, who had been in Thailand for at least two months, who had a positive urinalysis for opiates, and who had a history of daily use of heroin for at least one month. The majority had used heroin daily for three to five months.

A social work technician, who did the testing and collected the data, explained the nature of the study to these men; only two refused to participate. An explanation of the results of the MMPI was offered to encourage cooperation in being honestly self-descriptive. It was explained to the patients that participation would not influence their treatment disposition, and confidentiality was assured. Most of these patients reported symptoms of opiate withdrawal during hospitalization.

The control group (N=50) included men between the ages of 18 and 25 who had less than three years of military service and who had been in Thailand for at least two months. They were chosen at random from the complete rosters of the military units in the three areas where the heroin-dependent men were found—Bangkok, a base in north Thailand, and a base in the center of Thailand.

The social work technician personally invited each individual of this representative sample to participate in the study, explained the nature of the study, assured confidentiality, and offered the men the results of the MMPI. No one refused to cooperate.

Within two days of this invitation these men were

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tested by urinalysis. The tests were negative for opiate derivatives. The men gave negative histories of heroin use (except for rare experimentation), took the MMPI, and completed a social history questionnaire in the same manner as the heroin-dependent group. One man who had been invited to participate in the control group was discovered to be heroin dependent and was referred to the other group.

Apparatus

1. MMPI. The MMPI was chosen for use in this study because of its wide use for comparison purposes and for its acceptance as having some validity in measuring personality aspects in a broad way (1).

2. Shipley Institute of Living Scale (2). This brief intelligence test was chosen because of its ease of administration and reliability.

3. Social history questionnaire. With the help of Steven L. Murphy, we developed for use in this study a questionnaire regarding family, socioeconomic history, attitudes, history of difficulties with school or police, and drug abuse history.

4. Urinalysis. Urinalysis for opiate derivatives was carried out in the laboratory of the U.S. Army, using the free radical assay technique, gas liquid chromatography, and thin layer chromatography as described by Winter (3). The control subjects submitted their samples within 48 hours of invitation to participate in the study. Forty-eight hours is the conservative limit of time for the accuracy and reliability of the test. The heroin-dependent subjects submitted their samples upon admission to the hospital.

5. Work history. The social work technician interviewed each individual's work supervisor and asked a list of specific questions regarding his work history (see appendix 1). There were nine questions and a point was given for each positive answer, except for question 8, for which two points were possible. A perfect work score was 10. If prejudice or lack of knowledge on the part of the supervisor was apparent to the social work technician, someone in authority who was familiar with the individual's work habits was questioned instead.

6. Discipline record. The social work technician checked the individual's military record for Articles 15 and courts-martial while in Thailand. Article 15 is a formal but minor disciplinary action. No one in either group had been court-martialed.

Procedure

All tests and questionnaires were administered in the social work technician's office to groups of not more than two men. The tests were given to the heroin-dependent patients four to six days after admission to the hospital. By that time the patients were comfortable and had had no withdrawal symptoms for at least 24 hours.

The data were statistically analyzed using a chi-square test for two independent samples on the binary data. A two-tailed test was used to evaluate MMPI scores, years of schooling, work record, IQ, "closeness-to-parents" scales, number of drugs used, and a "father-distance" scale. A discriminant analysis was done on 10 of the variables.

RESULTS

Demographic Data

Unlike previous investigators (4–6), we did not find any significant correlation between urban background or minority group membership and heroin dependence: 32 percent of the heroin-dependent men (N=25) and 18 percent of the control group (N=50) came from a city of more than one million population; 28 percent of the heroin-dependent men and 24 percent of the control group were nonwhite.

The difference between our findings and those of other researchers may be due to the focus on nonwhite urban populations in the earlier studies. Such populations may have particular reasons for using heroin, but our data do not indicate any relationship between being nonwhite and from a large city and heroin dependence.

We were unable to determine the socioeconomic status of the families of 20 percent of the heroin-dependent men because they did not know their fathers' occupations or how much education they had had. We were thus unable to determine the relationship between heroin dependence and the socioeconomic status of the family. However, all of the men in both groups had sufficient income to provide for their ordinary needs and for some luxuries. The average rank was the same for both groups: E3 or E4. Thus the fact that these men used heroin did not seem to be related to current poverty or unemployment.

No differences were expected or found in regard to the marital status of the men in each group: 24 percent of the heroin-dependent men and 30 percent of the control group were married; 4 percent of the heroin-dependent group and 2 percent of the control group were divorced; 68 percent of both groups were single; and 4 percent of the heroin-dependent group and none of the control group were widowed.

MMPI Data

We found no significant chi-square relationships for any of the scales of the MMPI. Forty percent of the heroin-dependent group and 38 percent of the control group had two scales higher than the 70th percentile. Thus the groups did not differ significantly for psychopathology as measured by the MMPI (see table 1).

Previous studies (7–9) have found significant elevations of MMPI psychopathic deviate, hypomania, psychasthenia, schizophrenia, and depression scales of heroin addicts. These investigators have described the personality of the heroin addict as "severely disturbed," "immature," "oral-passive," and "psychopathic." Factors such as long-term addiction, geographic location, legal problems, and commitment to the Public Health Service hospital influenced selection in these studies. Perhaps these sample-biasing factors would tend to yield results suggesting a relationship between disturbed personality and heroin dependence.

TABLE 1
Mean MMPI Scores for Heroin-Dependent Subjects (N=25) and Control Subjects (N=50)

MMPI Score	Heroin Dependent Group	Control Group
Cannot say (?)	7.6	7.4
Lie (L)	3.8	3.4
Frequency (F)	6.4	7.2
Correction (K)	12.4	13.5
Hypochondriasis (Hs)	13.9	13.5
Depression (D)	21.3	18.6
Hysteria (Hy)	20.5	24.8
Psychopathic deviate (Pd)	24.8	23.0
Masculinity-feminity (Mf)	24.1	24.6
Paranoia (Pa)	11.8	10.1
Psychasthenia (Pt)	28.2	28.0
Schizophrenia (Sc)	28.5	30.2
Hypomania (Ma)	21.9	23.1
Social introversion-extroversion (Si)	25.1	25.8

Social History

Other studies (4, 10–12) have also described heroin addicts as being dissatisfied with their living and working conditions, as easily frustrated, and as having a low tolerance for frustration. Our data failed to support these findings. The great majority in both of our groups described themselves as satisfied with their work, their supervisors, life in Thailand, friends, and their relationship to the military service (see table 2).

Our data also failed to support previous studies (4, 11–19) that found heroin addiction to be associated with antisocial behavior even before addiction. One study (13) found addiction to be associated with antisocial behavior at a time (1914) when opiates were legal and inexpensive. A minority of our group of heroin-dependent men reported having "troublesome problems" with parents, school, teachers, or police. The heroin-dependent group did not differ significantly from the control group on these measures. Few of the men in both groups had had previous mental health care, and military records indicated that they had received few disciplinary actions (Article 15). No significant difference was found between the two groups for disciplinary actions.

The differences in our findings from previous studies can perhaps be attributed to the latter's focus on particular groups of addicts. These studies have involved individuals referred to the Public Health Service hospital, those with legal problems, or addicts residing in particular urban centers where the prevalence of antisocial behaviors was unusually high.

The groups in our study did not differ in regard to history of venereal disease. About half of the heroin-dependent men and half of the control group men had a history of venereal disease in Thailand. Thus at least half of the men in both groups were apparently sexually active. (Thailand is a country where such activity is very available and attractive.) This finding tends to discredit the idea that heroin-dependent men have difficulty with sexual functioning.

TABLE 2
Social History Variables in Heroin-Dependent Subjects (N=25) and Control Subjects (N=50)

Variable	Heroin-Dependent Group	Control Group
Percent generally unsatisfied		
With work	24	14
With relationship to supervisor	16	18
With life in Thailand	28	16
With relationships to friends	12	2
With relationship to Army	24	30
Percent having trouble during school years		
With parents	24	22
With school or teachers	24	16
With friends	4	4
With police	20	10
With school or police	36	22
Percent having had previous mental health care	8	10
Percent having received Articles 15	24	8
Percent having venereal disease in Thailand	52	50
Number of years of school completed	11.9	13.2*
Average score on work record questionnaire	6.2	8.1*
Average IQ	99.7	109.8**
Percent coming from broken homes	32	22
Average score on closeness-to-mother scale***	3.7	3.7
Average score on closeness-to-father scale***	3.08	3.24
Percent reporting fighting between parents	20	28
Percent reporting divorce of parents	24	16
Percent reporting others in family used alcohol or other drugs to excess	16	16
Percent reporting father died before they were 17	12	8
Percent reporting mother died before they were 17	0	8

* $p<.001$.
** $p<.005$.
*** These were 4-point scales.

A significant difference ($p<.001$) between the two groups in the number of years of schooling was found (see table 2). The heroin-dependent group had a mean of less than high school and the control group a mean of more than one year of college. The reasons for the difference were not obtained.

The work records also revealed a significant difference ($p<.001$) in favor of the control group. This confirms previous findings (11, 14, 16, 20, 21) that correlated inability to obtain and keep employment with heroin dependence. Despite their significantly poorer work record only a small minority of the heroin-dependent men in our study described themselves as unsatisfied with their work, their relationship to their supervisor, or with the military service. The skills required for the work are diverse, but regularity, ability to accept supervision, and dependability are prominent requirements for most military support positions such as these men filled. We know that these are the attributes which caused difficulties at work for many of these men. However, several of the heroin-dependent men had excellent work records.

Confirming previous studies (5, 11, 22, 23), our data indicated that the heroin-dependent men as a group were of average intelligence. However, there was a significant difference ($p<.005$) from the control group, whose mean

TABLE 3
Drugs Used by Heroin-Dependent Subjects (N=25) and Control Subjects (N=50)

Drug Used	Percents of Subjects Who Used Drug			
	Before Going to Thailand		In Thailand	
	Heroin-Dependent Group	Control Group	Heroin-Dependent Group	Control Group
Marijuana	60	52	80	56
Barbiturates	24	8	28	2
Amphetamines	28	22	28	18
Alcohol	56	80	44	66

TABLE 4
Variables Suggesting Distance from Father in Heroin-Dependent Subjects (N=25) and Control Subjects (N=50)

Variable	Positive Responses, in Percents	
	Heroin-Dependent Group	Control Group
Father's occupation unknown	12	6
Father's educational level unknown	20	12
Subject described self as other than close to father	56	42
Parents were divorced: subject lived with mother or in an institution	16	12
Father died before subject was 17	12	8

IQ was 10 points higher. This finding, combined with the fewer years of schooling and the poorer work record of this group, suggests that the heroin-dependent group had less ability to deal with the problems of living.

Previous studies (5, 10, 11, 14, 24) have also reported the prominence of broken homes, strong attachment to the mother, and the absence of a strong father among heroin addicts. We found no significant difference in the frequency of broken homes (growing up with other than both the natural mother and father). The other studies may have used subjects from disintegrated communities. Perhaps this would partially explain their finding a predominance of broken homes among addicts. No such relationship is indicated by our data.

In our questionnaire, the subjects indicated degree of closeness to each parent by choosing close, indifferent, distant, or never knew him/her. Close=4 points, indifferent=3 points, etc. No significant differences were found. Although closeness to the mother did not differ in both groups, more heroin-dependent men described themselves as something other than close to their father. Questions regarding parental fighting, divorce, excessive use of drugs and alcohol in the home, and death of parents revealed no significant differences.

Drug Use History

The heroin-dependent group had used a significant number of drugs other than heroin before leaving the United States (see table 3). Using as a criterion a list of 14 drugs that included amphetamines, hallucinogens, barbiturates, alcohol, and opiates, the difference in drug use before leaving the United States between the groups was significant ($p<.025$). The heroin-dependent group had used an average of 2.76 of the drugs on the list, and the control group had used 2.04.

An even greater difference in the same direction was found when this list was used to determine the drugs taken in Thailand. The heroin-dependent group had used an average of 3.44 of the drugs, and the control group had used an average of 1.46. This supports the reports of other investigators (12, 19, 25) regarding drug use by servicemen before their arrival in Southeast Asia. One of these studies (19) found that 59 percent of the heroin addicts in the sample had used "hard drugs" before going to Viet Nam; another study (25) found that 24 percent of heroin addicts used heroin before going to Viet Nam.

The relationship of heroin dependence to the use of marijuana and amphetamines is worth noting (see table 3). No significant relationship was found in our sample between previous marijuana or amphetamine use and heroin dependence. More than half of the men in the control group were using marijuana at the time of the study at least once a month; 14 percent used it daily.

Discriminating Variables

Ten variables appeared to differentiate the two groups: number of years of school completed; trouble with school or police; number of Articles 15 received; score on the work record questionnaire; IQ; coming from a city with over one million population; coming from a broken home (i.e., being reared by someone other than the natural mother or father); score on the closeness-to-father scale; father having died before subject was 17; and subject's not knowing occupation of father.

A discriminant analysis of these variables correctly identified 19 of the 25 heroin-dependent men (76 percent). Eleven of the 50 men in the control group were incorrectly identified as heroin dependent, a false positive error of 22 percent. This analysis indicates that the two groups were significantly different ($D^2=27.6$, $p<.01$, Mahalanobis D-square value).

Several variables were noted to consistently suggest a greater distance from the father in the heroin-dependent group. These data were analyzed giving one point for each of the variables (see table 4). The mean scores (1.16 for the heroin-dependent group and 0.78 for the control group) were not significantly different ($t=1.50$, $df=73$, $p<.20$) but worthy of further investigation.[1]

[1]A recent study by Schneider and associates (26) compared male drug addicts, other male psychiatric patients, and a control group. Using questions designed to indicate a distant or negative relationship with the father, these authors found significant differences between the drug addict group and the other two groups: the addicts had the highest scores for father distance.

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DISCUSSION

The dramatic differences between our data and those of previous studies appear to be due to the previous investigative focus on particular geographic, racial, criminal, and social groups. Patterns of drug availability, cost, and distribution probably influence the use of heroin. In Thailand, the setting for our study, drug distribution, drug cost, and legal issues made it easier for servicemen to obtain and use heroin.

Our population was drawn from both rural and urban sections of the United States and from every social and racial group. These men had employment, income, and support. Our hospital was the only evaluating agency for this population; every potential patient was referred to our agency. In this situation, a different perspective was possible in evaluating the pertinence of social and personality factors to heroin dependence.

The heroin-dependent group was found to have lower intelligence and poorer work and social skills. The difficulties in coping in these areas appear to be the primary problem for these men rather than measurable differences in particular personality patterns or psychopathology. A variety of personality styles was found in both groups; these did not give rise to differences that would clearly distinguish one group from the other.

Our clinical impressions of the heroin-dependent group were consistent with this analysis of the data. It was our impression that many of these men had gross difficulties in living and working (self-dependence, establishing relationships, etc.) even before they started to use heroin. However, some had above-average intelligence and adequate work and social skills. It was our clinical impression that the more intelligent and socially skilled heroin-dependent men had more problems with neurotic anxiety and depression. This issue requires further research.

Why the symptom choice of heroin abuse? In this situation, heroin was available, cheap, and its use was highly publicized as a major concern of the responsible authorities. It could induce tranquility and euphoria. Treatment and attention were virtually assured by its use. For some, it appeared to function as a self-destructive behavior.

These data and findings point out the need for a careful social and psychiatric evaluation of each person who presents with the symptom of heroin dependence and the need of many of these patients for long-term, supportive social rehabilitation.

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APPENDIX 1

Work Record Questionnaire

The following questions were asked by the social work technician in an interview with each subject's work supervisor. A point was given for each positive answer, except for question 8, for which two points were possible. A perfect score was 10.

1. Does he get the job done?
2. Does he come to work on time?
3. Does he work until the end of the duty day?
4. Is he accepted as part of the working team?
5. Is he willing to accept extra work if necessary, i.e., to work late to complete a job?
6. Does he generally accept supervision without unreasonable complaint?
7. Would you say he qualifies for a promotion on the basis of his duty performance?
8. How is his performance in comparison with other members of the staff performing similar jobs?
   a. better
   b. about the same
   c. not as good
9. Do you think he would be capable of performing in a supervisory capacity if the situation required it?

Implications of California's New Mental Health Law

BY ALBERT H. URMER, PH.D.

The author describes the impact that implementation of California's new mental health law and of its amendments has had on the development of community mental health programs. The new legislation has acted as a catalyst to the growth of local mental health programs by providing restrictions on involuntary treatment as well as fiscal incentives for local programs. The effect of the legislation on patients has varied according to patient needs and the resources available in the community. Although problems and controversies have arisen regarding the placement of chronic patients, impact on law enforcement, and quality of care, the service delivery system developed in response to the new legislation has resulted in a greater emphasis on crisis intervention, greater visibility of direct services, and increased community awareness and concern regarding mental health. The author concludes that mental health laws can become the catalyst for major changes in the mental health services delivery system.

THE LANTERMAN-PETRIS-SHORT ACT (LPS) went into effect in California in July 1969. This legislation limits involuntary commitment to mentally disordered persons who have been observed to be dangerous to others, suicidal, or gravely disabled; places time limits on the duration of commitment; and encourages the development of community-based treatment programs by shifting the control of all state mental health funds to local communities. The legislation further modifies the commitment procedures by removing the courts from the process and placing responsibility on the psychiatrist. The result of these modifications has been a major change in both the involuntary commitment process and the public mental health services delivery system.

At the time the LPS was implemented there was great national interest in the impact of this legislation. The ENKI Research Institute received a grant from the National Institute of Mental Health to evaluate the legislation's effect on the involuntary commitment system. A major portion of this paper is based on this research, which included a study of pre- and post-LPS delivery systems, legal procedures, and state hospital utilization. The study included a cohort of 600 patients.

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CRITERIA FOR INVOLUNTARY COMMITMENT

LPS criteria for involuntary treatment are limited to individuals who are dangerous to others (DO), dangerous to self or suicidal (DS), or gravely disabled (GD) due to mental disorder. The legislation mandates that the qualified person requesting the potential patient's admission must have observed the behavior which led to the conclusion that the potential patient was DO, DS, or GD. Clinical judgment that the patient represents a class of individuals who meet the behavioral criteria is not acceptable. Several other states have criteria similar to California's DO, DS, and GD, but California's requirement of behavior observation imposes unique limitations on the application of clinical judgment as justification for commitment.

LPS COMMITMENT PROCEDURES

LPS mandated major changes in the procedure for commitment of individuals for involuntary treatment and attempted to assure services after commitment. Analysis of the new procedures, including comparisons to pre-LPS procedures, provides considerable information regarding the dynamics of the delivery system. The basic components of the delivery system affected by LPS are outlined below.

Court Petition for Commitment

The pre-LPS procedure, which is prevalent in most states at the present time, was to file a petition with the court requesting that the potential patient be committed for evaluation because of a belief that the potential patient was mentally disordered. This petition usually required medical certification but not necessarily by a psychiatrist.

LPS modifies the procedure by requiring screening in the individual's home by an interdisciplinary team before action can be taken on the petition. If the team believes that the potential patient meets the legal requirements (DO, DS, GD) and that the only feasible procedure is involuntary hospitalization, this recommendation is forwarded to the court. The court then orders the individual into the hospital for a 72-hour evaluation. Simply being psychotic and requiring treatment is thus no longer a legal ground for involuntary commitment.

The result of this modification has been a 99 percent decrease in the number of petitions for involuntary commitment filed with the courts. The dynamics behind this reduction are directly related to the jeopardy that family members perceive in the new process. Before enactment of LPS, a family member could have a medical certifica-

tion signed by a family physician filed with the court. The potential patient would then be picked up by law enforcement officers without knowing beforehand that a petition had been filed. If the potential patient was severely disordered, the probability was high that he would be committed for an indefinite period of time without ever leaving the custody of the mental health system. Under LPS, the person who files the petition becomes visible to the potential patient during the prepetition screening; potential petitioners find this jeopardy intolerable.

Emergency Admission

Both before and after LPS, mental health legislation in California contained a provision that a mentally disordered person could be transported to an inpatient facility for evaluation and treatment. The major change effected by LPS is in the restriction of who can request the admission, i.e., only peace officers and specifically designated mental health professionals. The legislation also clearly defines the conditions and evidence needed to admit the individual: generally, the referring individual must have observed behavior that leads him to believe that the mentally disordered person is DO, DS, or GD. Bizarre behavior and apparent need of treatment are not sufficient reasons.

LPS has not had a significant impact on emergency procedures, although the clearly defined language has reduced the number of admissions of mentally disordered individuals who were admitted through the petition process before the enactment of LPS. These individuals are now admitted through the emergency procedure. This change is due to the reduction in the number of petitions, so that the individual remains in the community until he is in crisis.

Extended Treatment and Duration Limits

One of the major innovations of LPS is the imposition of time limits on the duration of involuntary treatment. An individual admitted for evaluation must be released after 72 hours. If he is not released, a psychiatrist has to certify in writing that the individual requires further treatment. Court intervention is not required at this time. If the certification is issued, the individual can be detained for involuntary treatment for an additional 14 days. This is a major departure from pre-LPS procedures as well as those prevalent in most other states, which call for court intervention at the end of the 72-hour period. With LPS, there are different procedures to be applied to DO, DS, or GD admissions at the end of the 14-day period.

If an individual is admitted as DO, there are two options—release or, if the individual is still dangerous based on observable evidence, a request can be filed with the court for postcertification for an additional 90-day period. Postcertification is an adversary procedure that requires testimony and evidence that the individual is dangerous and requires further treatment. This request must be filed no later than the 12th day of the certification period so that a court hearing can be held on the 14th day. If the postcertification request has not been granted before the 14-day time limit, the individual has to be released.

If an individual is admitted as DS, a psychiatrist can certify him for an additional 14-day period of involuntary treatment without any court intervention. At the end of the 28-day period, all patients who were admitted as suicidal have to be released.

If an individual is admitted and certified as GD, the treatment facility can petition the court to have a conservator appointed for the individual after the 14-day period. This is an adversary procedure; if a conservator is appointed, he has complete power over the patient for a one-year period. Conservatorships are renewable at the end of the one-year period through a repeat of the court procedure.

The time limit on duration of treatment and the changes in the procedures have had a minimal impact on treatment effectiveness and on the safety of the community. The mandated release of DO or DS patients has not increased the rate of violence or suicide by discharged patients in comparison with pre-LPS rates.

The 90-day postcertification procedure is seldom used. The primary reason given by psychiatrists for this fact is the difficulty of testifying in court and providing evidence of the patient's dangerousness. While this reason appears plausible, it is based on the inability of professionals in public institutions to become sufficiently familiar with the patient to make a valid prediction of the patient's future behavior. The professionals are unwilling to expose themselves to the cross-examination of the adversary procedure, which requires that clinical judgment be supported by factual evidence.

The conservatorship procedure has not had a major impact on placement or treatment of chronically disabled individuals except that the change to community programs has generally resulted in the placement of individuals in inadequate community facilities rather than in state hospitals. Individuals who were long-term patients in state hospitals are now long-term patients in local board-and-care facilities. Treatment for these patients continues to be lacking.

The mandatory reduction of the duration of involuntary treatment has had a major impact on the duration of treatment for both voluntary and involuntary patients. In the first two years after the enactment of LPS the average treatment duration of involuntary patients dropped from 180 days to 15 days, while the average duration for voluntary patients dropped from 75 to 23 days. The reduction in involuntary patient treatment duration was expected because of the legal restrictions, but the influence of the rapid discharge philosophy, which permeated inpatient facilities, carried over and reduced the duration of voluntary treatment.

IMPACT ON LOCAL PROGRAMS

Before the enactment of LPS, state funds were paid for the total cost of patients in state hospitals and for 25 percent of the cost of local programs. The desire to isolate

the mentally disordered in state hospitals was therefore fiscally rewarding to the community. By changing this pattern, LPS became a major catalyst in the development of community mental health programs. LPS places all funds for mental health programs under the control of local communities. The total cost of mental health services is shared on a 90 percent state/10 percent local basis, independent of the location of treatment. Inpatients in state hospitals and outpatients in the local community are reimbursed on the same basis. As a result, the percentage of money spent on local programs increased from 32 percent to 74 percent of all mental health funds in the first three years of LPS. Concomitant with the increase in outpatient and day-care services, there was a significant reduction in inpatient services.

The increase in outpatient services appears to have had an unanticipated impact on a new group of clients who had not previously used public mental health services and who were never in jeopardy of involuntary commitment. The legislation intended that the local programs would divert individuals who were high risks for hospitalization, not that it would reach a new group of clients. A significant portion of the potential target population is not being reached by the local programs for many reasons.

IMPLICATIONS OF LPS

The broad-based implications of LPS are not necessarily reflected in the empirical findings summarized here. Some of these implications are of critical importance to states that may be considering the development of similar legislation and to the attitudes of professionals toward the mental health delivery system. While the experience in California has not provided solutions, it has identified issues which require resolution and upon which experimental work should be focused.

It appears that there is relatively little correlation between treatment duration and treatment outcome. The procedures for delivery of mental health services as an integrated system must be reevaluated; the components necessary for continuity of care must be clearly defined. There is some evidence (1) that inpatient services need to be utilized only during crisis intervention, when isolation from the environment is mandatory. We have also found (1) that the duration of inpatient treatment should be minimal, rarely exceeding five days. However, it is important that the treatment component be continuous and not necessarily tied to the domicile of the patient.

Mental health professionals must begin to separate treatment from the place of domicile; involuntary treatment and hospitalization are not synonymous. We must focus on the total milieu and consider the patient as only one aspect. With a global approach we will start considering which aspect to focus our energies on. In some cases environmental manipulation will be found to be a more effective treatment modality than modification of the patient's response to the environment.

The ENKI study (1) also found very little correlation between professional prediction of behavior and actual behavior. Therefore, an extension of the duration of involuntary treatment cannot be justified on the grounds that it will reduce future violence or suicides. It was the need to ensure that a patient would not be violent that resulted in the relatively long commitments before LPS. The staff had to be confident that the patient would not be dangerous. The professionals' uncertainty regarding their predictive abilities resulted in an unwillingness to assure society that the patient would not commit an act contrary to society's concept of its own safety and that of the patient. The result was indefinite commitment.

LPS reversed this process by requiring evidence of dangerousness; this resulted in the rapid discharge of patients. The dilemma of prediction arises because the public mental health delivery system does not provide sufficient contact between the professional and the patient to permit familiarity with the patient and his reactions to environmental stress. Prognosis is therefore poor, and society condones the incarceration under the guise of protecting itself or the patient. Even with sufficient contact and understanding of the patient's dynamics, one is still faced with the problem of controlling the environmental conditions that might lead to undesirable behavior in the patient who is adversely stimulated.

Experience with California's new law has also shown that the mental health system is frequently used to house socially incompetent individuals and that alternative systems are developed when this system becomes unavailable. For example, a significant proportion of individuals had been committed to state hospitals before LPS not because they were violent or suicidal but because of their bizarre behavior and because they were a nuisance to society; this was coupled with society's traditional fear. Since LPS, these individuals have been ineligible for commitment, but now their behavior comes to the attention of law enforcement agencies; they are therefore placed in jail.

Although the duration of their incarceration under the penal system is short, such individuals recycle frequently. We feel that this problem has developed because neither society nor mental health professionals have been willing to accept the reality that the mental health system had been used as a convenient resource to isolate the socially incompetent. Little preparation has been made for the influx of this group into society. We have to accept the fact that this group needs both protective care and assistance in daily living.

A less obvious but still important change brought about by LPS is the elimination of the role of the court in the early commitment process and the placement of responsibility on the psychiatrist. Evaluation of this procedure has shown that it is effective and results in a more critical evaluation of the need for commitment. One could have anticipated this result because the pre-LPS commitment process divided the actual responsibility. Psychologically, neither profession had to accept the ultimate responsibility for the commitment. LPS legislation places that responsibility on the physician, who, after all, makes the ultimate recommendation on which the courts should base their judgment.

LPS has also shown that a rapid and unplanned shift of funds from the state hospital system to community-based programs does not necessarily result in the development of effective precare or aftercare programs as alternatives to hospitalization. It is important that legislative goals be clearly defined and that effectiveness criteria be included in the legislation.

RECOMMENDATIONS

The study of the impact of LPS has led to some basic recommendations for consideration by state legislatures and the mental health profession.

1. The issues of involuntary treatment and inpatient services must be separated. There is very little evidence that involuntary treatment in a confined setting is more effective than other modalities in other settings. Incarceration should be limited to situations where the patient has to be removed from his environment for therapeutic considerations, society's safety, or his own safety.
2. Public mental health delivery systems must increase their consideration of the total environmental structure and deal with the patient as an integral part of it rather than as an isolated organism in a psychological void. The greatest potential for effective intervention is through a global approach to treatment.
3. Legislatures should place more emphasis in their legislation on development of policies than on detailed treatment procedures. Before this change can occur, the mental health profession must convince legislative bodies that they have the skills to implement the policies and that as a profession they will attempt to meet legislative goals.

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APA Grant Program for Minority-Group Medical Students and Residents

A small number of qualified minority applicants (including but not limited to American Indians, Asian Americans, black Americans, and Spanish-speaking Americans) will receive residency stipends, assistance in selecting a residency program, expenses to a yearly meeting with other minority fellows to share experiences and administrative help through APA's Office of Minority Affairs. The program is sponsored by APA, with funds provided by the National Institute of Mental Health.

Applications are being accepted through March 15, 1975, for residencies beginning in July 1975; after that date applicants will be considered for subsequent years. Applicants must be U.S. citizens and must have graduated from a U.S. medical school or possess the ECFMG certificate.

For further information write Jeanne Spurlock, M.D., Office of Minority Affairs, American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009, or call (202) 232-7878.

Evaluation of a Regional Indian Alcohol Program

BY LAWRENCE G. WILSON, M.D., AND JAMES H. SHORE, M.D.

The authors analyzed follow-up data collected by an Indian counselor and a psychiatrist on 83 American Indian alcoholic men. Follow-up status was judged by an interdisciplinary panel according to a six-step rating scale. The 44 percent improvement rate compares favorably with other treatment programs, especially in view of the selection process, which favored difficult patients. The authors suggest that the interdisciplinary rating panel is an approach that can prevent erroneous judgments of the drinking status of American Indians.

THE RAPID GROWTH of alcohol treatment programs for American Indians within the past three years has created the need for a systematic evaluation approach. This paper reports a follow-up evaluation of 83 American Indian alcoholic men from five major Northwest tribes who were treated in a regional intertribal and interagency alcohol rehabilitation program. Their follow-up status was assessed at an average of 18 months after inpatient discharge.

The purposes of the research were as follows: 1) to develop a method of assessing the follow-up status of Indian alcoholics; 2) to identify the characteristics of Northwest Indian drinkers who had been treated in this program; 3) to analyze the follow-up status data for differences between tribal groups and differences on demographic, social, and health variables; and 4) to compare these data with results from other American Indian alcohol treatment programs.

ALCOHOL TREATMENT FOR AMERICAN INDIANS

Alcoholism as a major health problem of American Indians has been widely discussed by both Indian and non-Indian sources (1). Many theories and viewpoints that attempt to explain the extent of drinking in Indian populations have been reported in the anthropological and sociological literature in past years. However, the earliest report on the effectiveness of alcohol rehabilitation programs for Indian people appeared in the literature in 1968. Ferguson (2) and Savard (3) reported on separate projects that evaluated the outcome of treatment with disulfiram in Navajo communities. Their reports described the therapeutic effect of disulfiram positively and recommended its continued use. Shore and Von Fumetti (4) reported on three tribally sponsored alcohol programs, emphasizing four factors: 1) the involvement of Indian people in planning and operating their own programs; 2) the treatment philosophy that had evolved within the context of the Indian communities; 3) the relationship of the court to these programs; and 4) the need for uniform standards to evaluate patients.

The regional alcohol rehabilitation program described in this paper is located in the Pacific Northwest, which includes the states of Washington, Oregon, and Idaho. The treatment service was coordinated by the Mental Health Program of the Indian Health Service and was a joint effort by tribal alcohol programs, the Indian Health Service, and a private inpatient treatment center.

Northwest Indian Tribal Programs

Indian tribes of the Pacific Northwest consist of 33 diverse and geographically isolated groups with two distinct cultural backgrounds, the Northwest coastal and plateau cultures. The large number of tribes and the absence of Indian hospitals necessitated sharing of the inpatient services for alcohol treatment.

All tribes were included in the coordinated rehabilitation service. Five tribal alcohol programs from four plateau tribes and one coastal tribe were invited to participate in the evaluation of this program. These tribes were selected because of their larger populations and their established reservation-based alcohol rehabilitation programs. Since 1969, these five programs had worked cooperatively with the Indian Health Service to establish the regional treatment center.

The reservation-based tribal alcohol programs are totally outpatient in design. They receive funding support from the National Institute of Alcohol Abuse and Alcoholism through their tribal governments. Mental health consultation is available through the Mental Health Branch of the Indian Health Service, a regional consultation service. A third component of the coordinated treatment program is a private residential treatment center for male problem drinkers that is located on a major Northwest Indian reservation. The inpatient program

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The authors wish to gratefully acknowledge the aid of Ms. Carolyn Dearborn, Program Assistant, Mental Health Office, Portland Area Indian Health Service.

consists of a standardized regimen of group and individual counseling and an intensive alcohol education program. Within this general program, a special treatment plan was developed for Indian patients that includes regularly scheduled sessions with Indian counselors and outpatient follow-up on the home reservation. The coordinated treatment aspects of this rehabilitation program include case identification by the local tribe alcohol program (usually by an Indian alcohol counselor), referral through the Indian Health Service to the regional inpatient center, including evaluation of physical status and special psychiatric examination where indicated, and coordinated follow-up after discharge by each of the tribal programs and the Indian Health Service. Thus, the treatment program is regional in scope, intertribal in nature, and interagency in operation.

METHOD

The study sample consisted of 83 Indian men from the Colville, Spokane, Warm Springs, Yakima, and Lummi tribes. All tribes were of the plateau culture except the Lummi, who are a coastal tribe. These five tribes consist of approximately 15,000 reservation Indians, 60 percent of the region's reservation Indian population. Eight additional tribes were represented by 1 individual each. The sample included all Indian men referred to the regional inpatient treatment center during an 18-month period from January 1971 through June 1972. Since this was the beginning of the regional treatment program, Indian women were being referred in smaller numbers and were not included in the study sample.

Information was collected systematically by the Indian alcohol counselor for each subject. This included demographic data, education and employment background, arrest record, and health history. The data were compiled from existing case records and personal interviews. Health histories were gathered by the project psychiatrist through a review of medical records. A profile was developed on each subject that was used as the data base to assess follow-up status.

Subsequently, a rating panel met on each reservation to determine the follow-up status of all individual patients. The project psychiatrist (LGW) met with an Indian alcohol counselor from the local tribal program and a psychiatric social worker who was also working in the local Indian community. This three-member panel employed a six-step rating scale patterned after that developed by Fitzgerald and associates (5). The rating was specifically aimed at defining the patient's status in areas of personal, family, and community functioning in relationship to his current drinking pattern and emotional adjustment. All information from the profile of individual patients was shared with the panel, as well as current information about the patient's functioning, which was usually supplied by the Indian alcohol counselor. Anecdotal information from friends, relatives, or other knowledgeable community people was included. Each patient (and his spouse, if applicable) was rated separately by each of the three panel members. After separate ratings, a group consensus rating was given, which was used in the final analysis. There was a high degree of interrater agreement, which indicated that the Indian alcohol counselor and the project psychiatrist agreed about patient ratings.

RESULTS

Demographic Data

The average age of the subjects was 41 years, with a range of 21 to 67 years. Indian men in their 30s and 40s were most heavily represented (N=25 and 24, respectively). Subjects in their 20s (N=12) were underrepresented in comparison to an epidemiological pattern of an entire Northwest tribal population (6). Twenty-two of the men were married and 61 were unmarried. Educational experience ranged from the fourth grade to two years of college, with the average being a ninth-grade education. Forty-nine subjects were employed, either full-time or part-time, and 34 were unemployed. Of the 83 subjects, 40 had had military service. There was a representative sample of religious affiliation throughout the group, with 41 Catholics, 12 Protestants, and 11 members of the traditional Indian religion.

The majority of the subjects did not fit the stereotype of highly mobile "skid-row" alcoholics: 68 of the 83 were living on reservations, and 45 had lived in their present home for more than one year. Using the two-factor social class index of Hollingshead and Redlich (7), distribution was predominantly in Classes IV (N=9) and V (N=55). In a further refinement, an Indian social class rating was assigned, using the method of Shore and associates (6).[1] With this technique, there was 1 subject in Indian Social Class I, 28 in Class II, and 36 in Class III (unknown=18). Since the ratio of these classes was 1:2:1 in a representative sample of one total Northwest tribal population (6), our sample is significantly overrepresented in Class III. In the epidemiology pattern for one tribe, alcoholism was more evenly spread through the classes, although the most severely impaired alcoholics were from Class III.

A history of arrest records, obtained for 64 of the 83 subjects, indicated that 8 subjects had had no arrests, while 56 had one or more. There was no previous treatment history in 24 of the 83 subjects; 29 listed one or more prior rehabilitation programs. Of the 68 subjects who answered a question assessing their own medical status, 34 judged themselves to have good or excellent health, while 34 considered themselves to be in fair or poor health. Fifty-two individuals reported one or more hospitalizations, usually related to alcoholism; 16 subjects were admitted a second time to the inpatient center and 2 subjects had three inpatient admissions. Many sub-

[1]Since most reservation Indians fall into the lowest Hollingshead-Redlich categories, Shore and associates (6) divided the Indian population into three main modal distributions of Hollingshead-Redlich scores. This gave a distribution they called "Indian Social Class," thought to be a truer description of the social stratification of Indian communities.

TABLE 1
Follow-Up Status of 83 Indian Alcoholics

Rating*	Number
Clear improvement	
1. Complete abstinence in past year or since discharge from treatment facility and maintaining vocational, home, and family responsibilities.	11
2. Occasional or sporadic drinking in past year or since discharge, but maintaining vocational, home, and family responsibilities.	12
Erratic improvement	
3. Drinking periodically or regularly during past year or since discharge, but no outstanding community problems or severe effects on home and family.	13
No improvement	
4. Drinking to the extent that vocational and family responsibilities are not maintained—has come to the attention of the community for drinking in the past year or since discharge.	35
Lost to follow-up	
5. Drinking status unknown.	10
6. Deceased.	2

*Based on the classification system used by Fitzgerald and associates (5).

jects in the group had experienced severe alcoholic withdrawal, but the medical records were not complete enough for a statistical analysis. Disulfiram played a minor role in the follow-up treatment plans of this group in spite of the positive results previously reported with Navajo alcoholics.

Follow-Up Status

In order to summarize follow-up status and compare the results with the outcome of other treatment programs, categories 1 and 2 of the six-step classification (see table 1) are considered to be clear improvement, category 3 represents erratic improvement, and category 4 indicates no improvement. Categories 5 and 6 indicate loss to follow-up. Clear improvement was demonstrated in 28 percent of the subjects (N=23), erratic improvement in 16 percent (N=13), and no improvement in 42 percent (N=35). Twelve subjects were lost to follow-up. Thus, some improvement was seen in 44 percent of the patients and no improvement in 42 percent at follow-up.

Follow-up status was then compared to specific characteristics in the profile of the Indian alcoholic. There were no significant differences in follow-up status between the five major tribal groups or between decade of life, type of marriage (intra-, inter-, or extratribal), type of religion, or Indian social class (which includes scores for type of employment and level of educational attainment). Several comparisons deserve special comment. We observed a decreasing proportion of patients remaining in the "clearly improved" category with increasing time lapses since discharge from the inpatient facility. Sixty-six percent of those who had been discharged less than 12 months previously were clearly improved, as compared with only 26 percent of the patients who had been out longer than 12 months. Follow-up status and a history of no arrests were positively correlated—6 of the 8 subjects who had a history of no arrest showed significant improvement. However, the reverse was not true, i.e., those subjects with a history of multiple arrests did not necessarily receive poor follow-up status ratings—8 out of 29 subjects with four or more arrests showed clear improvement at follow-up, 5 had erratic improvement, and 16 showed no improvement. Also, the lack of a significant relationship between follow-up status and religious affiliation did not substantiate earlier impressions of many counselors, who hypothesized a positive relationship between treatment outcome and traditional Indian religion. Instead, there was a trend for Protestant subjects to show greater improvement at the time of follow-up ($.05<p<.10$). Eight out of 11 Protestants showed improvement (clear or erratic), while only 2 were considered to have shown no improvement.

Married subjects had a significantly higher improvement rating than those who were unmarried (i.e., single, separated, divorced, or widowed) ($\chi^2=10.88$, $p=.005$). Less than 20 percent of the married subjects were unimproved, while over half of the unmarried subjects were unimproved. Drinking status of wives was known for 16 of the married subjects, and the man/wife drinking status was a direct one-to-one relationship for 10 of these couples.

In the group of 18 subjects who were readmitted for two (N=16) or three (N=2) inpatient treatment sessions, 8 showed improvement, 7 showed no improvement, and 3 were lost to follow-up.

DISCUSSION

Since the components of this regional Indian alcohol program include inpatient treatment and geographically distant follow-up resources, a documented improvement of 44 percent at an average of 18 months after discharge from inpatient care compares favorably with other treatment programs. Shore and Von Fumetti (4) reported improvement ratings of 56 percent (28 percent clear and 28 percent erratic improvement) for 642 Indian alcoholic patients treated in three tribal programs. However, these were outpatient programs, and it is likely that referrals to the program we have described were selected from the more difficult cases in each counselor's outpatient caseload. This would also account for the overrepresentation

of subjects from Indian Social Class III in the treated population and would indicate that the most socially disadvantaged drinker did have access to the program.

There was no evidence from our study to support Ferguson's (2) conclusions that older, more traditional Indian men benefit most from an alcohol treatment program. However, Ferguson was working with Navajo rather than Northwest Indian tribes and with a program that strongly emphasized disulfiram. There was no significant difference in response to treatment among different age groups in the Northwest program, but the underrepresentation of subjects in their 20s points to an exclusion of the younger Indian alcoholic from this patient sample. Perhaps an alcohol program with an inpatient component is not an appropriate resource for the young Northwest Indian male. It is also possible that the case-finding approach favors older men with more obvious signs of severe alcoholism.

The problems encountered in the collection of data and in the coordination of diverse resources in this program were enormous. For example, in the review of medical records, an alcohol problem was identified for 89 percent of all subjects, but a definite follow-up plan for alcoholism was recorded on only 23 percent of these charts. The data were available in the local Indian community, but it was only with great effort that all sources were brought together. Levy and Kunitz (8) have commented that

> the numerous difficulties which have plagued the data gathering process in studies of American Indian drinking, while they remain with us, may be overcome to a great extent by the use of more uniform methods of investigation, explicit definitions, and whenever possible, by a multidisciplinary approach. As long as the methods of one discipline remain unchecked by the use of other methods, erroneous interpretation of the findings will be unnecessarily frequent. (p. 25)

The interdisciplinary rating panel described in this study is an approach that provides a check for erroneous judgments of Indian drinking status. Perhaps with broader acceptance of uniform evaluation standards, systematic inquiry into the effectiveness of Indian alcohol programs can lead toward a solution of the major health problem of American Indians.

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The Future Educational Needs of Psychiatrists

BY ROY R. GRINKER, SR., M.D.

The author states that psychiatry must work at defining its boundaries as a discipline before the question of how to educate future practitioners can be answered. The medical student is presented with a bewildering array of approaches to psychiatric treatment and is pressured to choose quickly. The author calls for collaboration among the various parts of psychiatry—social psychiatry, community psychiatry, research, biochemistry, etc.—with other university faculties such as the humanities and basic sciences. The goal of this collaboration would be to produce a mature professional capable of dealing with the whole person. He also calls for a greater emphasis on research to equip psychiatry with the necessary knowledge to establish its role in our ever-changing contemporary society.

IMPLIED IN THE TITLE of this paper are questions that can no longer be answered by psychiatrists because our discipline has lost its boundaries. Psychiatry has been incorporated and defined by the social systems of the human consumer and regulated by superimposed governmental bureaucratic controls. How then can we answer the questions of the future for which we should be educating psychiatrists?

Perhaps we do not differ much from other service and scientific endeavors as we view the attempts to predict what changes will occur in the rapidly approaching next century. Indeed, a new, supposedly scientific discipline called "futurology" is engaged in the game of betting on what comes next. As far as I can tell, a succinct statement of the conclusions of this discipline is, "More of and better than."

So much of what has happened in the last decade denies the future psychiatrist an opportunity to mature. If a psychiatrist needs any one quality, it consists of a high level of maturity achieved through being exposed to a wide variety of life experiences. The psychiatrist should have the experiences of suffering, succeeding, and losing his adolescent narcissistic self-evaluation and his grandiose idealism. Only by attaining his own lifestyle and a stable self-system is he able to help others within a mutually trusting and respecting therapeutic alliance.

HURRYING MEDICAL EDUCATION

There is now a mad rush to hurry medical education. It has been shortened to three years, and more and more time has been given over to electives for students who are not able to choose. The abolishment of the internship and the direct promotion to residency means that specialty education has to be chosen, applied for, and accepted even before the full round of clerkships has been experienced. No wonder the medical student is confused and the first-year resident's syndrome of anxiety and depression is worsened. It is interesting to hear how these youngsters choose their future discipline—by means of advice from others rather than through their own motivation. Their exposure to psychiatry in medical schools is brief and irrelevant. They apply for a strange mixture of residencies.

The internship functions not only to increase the student's knowledge but, more important, to increase his capacity to deal adequately with other human beings and to become professionalized. Fortunately, at Michael Reese Medical Center we have always started our residents on

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The papers in this section are grouped around a specific topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.

October 1 so that all of the staff are back from their summer vacations and available for preliminary orientation. We now insist that between graduation in June and starting the residency in October the students take a mini-internship in medicine, pediatrics, or neurology.

Probably the best evidence for the deficiencies in psychiatric education in medical schools is the experience of our liaison psychiatrists who work on the medical and surgical wards. Over the last 30 years the house officers from medical schools all over the country have become more knowledgeable about organs and organ systems, but they are still woefully deficient in their grasp of illness-related problems, conflicts, interpersonal difficulties, and emotional fluctuations in the whole person. Yet some of these house officers aspire to go into family medicine!

Turning back to the psychiatric resident who is confronted at the beginning of his career with a system fragmented into parts belonging to what we as teachers recognize as psychiatry, I need only mention the various forms of treatment, the specialized peer group programs, and the multidisciplinary aspects of research. To become a general psychiatrist the resident has to taste these various parts all too briefly during his first two years of residency (1). Then he may elect one part of the specialty of psychiatry for a special track during his third year.

MEDICAL OR SOCIAL PSYCHIATRY

There has been a peculiar debate during the last several years between those psychiatrists and clinical psychologists advocating the medical model of psychiatry and those adhering to a so-called social model. I consider this dichotomy one of the worst possible examples of dualistic thinking. Complementarity instead of separation has been and is the goal of most psychiatrists. However, to ensure our concern with more than the internal subjective complaints of our patients and their social behavioral incompetence, we need to know and teach our students the components of the medical model to extend their focus beyond interpretative explanations.

This means a knowledge of diagnostic categories and the current nosological classification; a knowledge of biogenetic and organic structural and chemical dysfunctions; a knowledge of psychopharmacology and at least the rudiments of biochemistry; and a familiarity with characteristics, predispositions, and approaches to diseases of development and regression in various age groups. The psychiatrist must be a doctor; he must demonstrate in practice that he is not forbidden to look at or touch the body even though his main interest is in mental disturbances.

Unfortunately, the future psychiatrist hears from his teachers (who must conform to the demands of governmental funding agencies that the student be encouraged to do community psychiatry) about a nonsystem planned for primary prevention—an illusion worthy only of bureaucrats. The new psychiatrist cannot be a public health physician, a sociologist, or a social engineer to alter the horrible socioeconomic predispositions to the more serious mental illnesses.

The workers in the field know that the "psychiatrization of life," as defined by Cerrolaza (2), is a by-product of illusory thinking. The psychiatrist makes a poor politician when working with community lay boards who have been appointed according to mandate. The boomerang of all these "promises, promises," to borrow the title of a recent play, is less effective psychiatric care and more disorganization and confusion in the field.

Stemming not from the community mental health movement but from psychiatrists who are currently engaged in private practice is the mixture of private practice with part-time paid jobs in institutions and in-hospital services dedicated to caring for the indigent or the working poor. There is no sharp separation of those who deal with the public or the private sector; doctors who work in the public sector universally moonlight in private practice.

Although the individual psychiatrist, with some exceptions, is not politically astute, psychiatric organizations have become increasingly political. Scientific sessions are often replaced by policy discussions in an effort to defend psychiatry against the controls, restrictions, and demands of the government; to contest impoundment of funds; or to issue late position papers on issues affecting the mental health of our citizens. But the political psychiatrist has been unfamiliar with the systems aspects of the parts of psychiatry that seem to be in conflict.

PLURALISTIC SOCIETY AND PSYCHIATRY

Returning to the real world of psychiatry, we have a pluralistic concept of the psychiatries often so disparate and sometimes so contradictory that the psychiatrist as practitioner or scientist rides madly in all directions (3). However, he is not alone in his confusion because our society is pluralistic. It is divided into ethnic, social, and economic groups, each of which has different problems in coping with the strains of the mythical whole.

Furthermore, what we classify as diseases or at least divisions in our notoriously inaccurate and inadequate nosological classification do not remain steady. Cross-sectional studies reveal shifts in outward behaviors, in disturbances in thinking, and in inner feelings. Not only do such shifts occur in individuals but there are profound changes in diagnostic entities—from dramatic histrionic excitements to highly constricted, inhibited lifestyles. Schizophrenia just isn't what it used to be!

We have now faced the vertigo-inducing problems. Psychiatric diseases are changing, deviances in individuals shift over the individual's life span, society is changing faster than ever before, and educational facilities and methods are changing. Are we then speaking of educational needs of psychiatrists or the psychiatric needs of the public? Neither can be defined with any degree of certitude, and I would advise the beginner not to believe anyone who speaks positively about the future. Many of us have wished that we too could start again to specialize in

a new, promising, and exciting phase of psychiatry without having to consider the fact that all phases belong together as parts of the whole.

THE TIME PROBLEM IN EDUCATION

The time problem in the education of future psychiatrists is uppermost in our minds, but there has been no general solution. Some feel that the similarity of training programs produces a stereotyped result because curricula are almost identical everywhere in the country. Training programs differ only in the quality and experience of the teachers. Perhaps each institution should be identified by its major goal, but that too demands a premature decision on the part of the student. Perhaps the residency program should be extended by one or two years, just as child psychiatry includes a fourth-year fellowship. But increasing the time goes against the national trend toward shortening the time of education. Perhaps the third year should be a mobile period during which the student may finish his education at a place that offers the best special track chosen by the resident during his two years of general or eclectic experiences. This too demands sacrifices that most highly autonomous institutions are not willing to make.

The theme of the 1974 annual meeting of APA, "Man and His Cities 1974; Survival in 1984?" was unduly pessimistic in that it connoted the possible nonsurvival of psychiatry in 1984. I believe that with a sensible national health program backed by the national psychiatric, psychological, and social service organizations, care of psychiatric patients may be able to adapt to the changing times. There will always be a place for our services because collectively we belong to the only field concerned with the whole person.

RESEARCH AND CHANGE IN PSYCHIATRY

Brodie and Sabshin (4) reviewed the number and types of research articles published in *The Archives of General Psychiatry* and *The American Journal of Psychiatry* during the last decade. At the beginning of the decade there was a weak emphasis on research (37 percent of the papers). This emphasis had increased by the end of 1972 to 48 percent. Declining governmental support may reverse this trend in the next decade. In order of frequency within the biopsychosocial system, articles on biological research (genetics) were most frequent, psychological articles second, and sociological articles third. In order of kinds of topics, mechanisms (dynamics) came first, therapy (biological) second, and etiology third.

We cannot stand still and teach what either is doubtful or should be discarded. Our hope for the future rests not only in adapting to changing social systems but in creatively developing new understanding and better methods. In plain terms this means more emphasis on research. For this we need more than the kind of education for which the medical schools are solely responsible; this system has failed badly in the last several decades. We need the whole university. The faculties of the social sciences and humanities and preclinical faculties of basic sciences must become collaborators in education with appropriate clinicians in the medical school. The success of such learning experiences involves faculties willing to leave the confines of their departmental or specialty compounds and enter into a viable and effective transactional process with new sets of colleagues.

In growth and development the trend is upward from relative undifferentiation, toward differentiation, toward greater refinement in development of control mechanisms, and toward decline in old age. There are also processes that push the organism back to a more undifferentiated state. This is perhaps more easily understandable when we speak of psychological regression, but it occurs in physical regression as well. If we can get the student to recognize that there are no dichotomies between genetics and environment, no sharp differentiations between levels of development, and no independence of any phase of the life cycle, I think that we will have developed what might be called the philosophy of ontology in relation to scientific disciplines and to the therapeutic aspects of medicine (5).

The future of psychiatry hinges on changes in the shifting behaviors of man in a changing society. We cannot predict these changes at this time. For example, the wholesale increase in return of patients to the community from state mental hospitals may increase the pathogenetic biogenetic pool. Shifts in family constellations from the extended to the nuclear family, increased urbanization, changes in the kind of parenting, and other social and economic factors may result in changes in the kinds of coping available to succeeding generations.

SOCIAL CHANGE AND SOCIAL PSYCHIATRY

All of this means that psychiatry is necessarily part of the processes of social change—at least in diagnosis, treatment, and (possibly) preventive measures. All the more reason why solid, well-planned research in all of the many disciplines of psychiatry should be supported and greatly extended if our civilization is to be kept from nurturing the seeds of its own destruction. We can no longer afford the luxury of making public generalizations for narcissistic purposes. Those who treat should treat adequately the problems of difficult lives. Those who investigate should have adequate support to be free to research what needs to be researched. But these endeavors do not satisfactorily define what is popularly called social psychiatry.

Social psychiatry is a well-meaning term but completely inundated with confusion, multiple definitions, and misunderstandings. Its basic science is epidemiology, which is concerned with estimates of incidence and prevalence of mental illness. It deals with differential distribution of mental disease geographically and in various social classes. However, it is obstructed by resistance against statistics and faulty psychiatric taxonomy. Nev-

ertheless, institutions will have to document their utility some day. This is not now possible.

What so-called social psychiatry, with its politicalization of primary prevention, does is create an identity crisis in the student: he or she is seduced away from treating the individual patient. The individual is considered worthless in comparison with communities of various sizes. Social psychiatry turns away from the current explosion of research in biological psychiatry. It obstructs our striving toward a modern neuropsychiatry. Social factors must be added to any formulation in psychiatry, but not as goals in themselves.

To repeat the statement in the first sentence of this paper, our discipline has lost its boundaries. If we plan to educate therapists and investigators we need to redefine our system of a biopsychosocial conglomerate in order to educate wisely for the future. If we fail in this task we face what Bertrand Russell (6) stated so pessimistically:

> The near future must be either much better or much worse than the past. Which it is to be I do not know, but those of you who are still young will know before very long. (p. 64)

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Emotional Problems of Residents in Psychiatry

BY MAJ. ANDREW T. RUSSELL, MC, USA, ROBERT O. PASNAU, M.D., AND ZEBULON C. TAINTOR, M.D.

The authors used a questionnaire technique to determine the magnitude of the problem of emotional illness and poor performance during psychiatric residency, the procedures that are used to screen for or help disturbed residents, and characteristics that differentiate residents who are at risk. The data indicated that residents who have problems that lead to termination are rarely free of emotional disturbance. The general belief that women, foreign medical graduates, and minority group members are at higher risk for problems during residency was not supported; however, younger residents and transfers from other programs appeared to be at risk. A disturbing finding was the high rate of suicide reported. The authors stress the need for further work with the "marginal" resident and for research on screening and supportive procedures.

THE PSYCHIATRIC LITERATURE in recent years has reflected a growing concern with the subject of emotional illness among psychiatrists during their training years. In 1962 Halleck and Woods (1) pointed out the lack of reliable statistics on the causes of failure in residency training programs. In what is now considered a classic study of psychiatric residents, Holt and Luborsky (2) emphasized the changes that take place as the resident undergoes a maturational process which leads to the emergence of a new adult identity. Pasnau and Bayley (3) reported an increase in depression among first-year psychiatric residents, as measured by the Minnesota Multiphasic Personality Inventory (MMPI). Duffy and Litin (4, 5) looked extensively at the emotional problems of physicians and the relationship of these problems to the training period. They emphasized the importance of evaluation, screening, and counseling during the medical school years. The importance of such factors as family relationships, drug and alcohol abuse, the special situations faced by the woman resident, and the relation of these factors to emotional illness among physicians were also noted in these studies (4, 5). Garetz (6) examined factors that might predict success or failure among psychiatric residents and found that although some aspects of the MMPI were helpful in distinguishing outstanding from poorly functioning residents, further research on the problems of women residents and foreign medical graduates was necessary.

Kelly (7) used a questionnaire technique to study the incidence of both suicide and emotional problems among psychiatric residents. He found an incidence of psychiatric disabilities of "something over four percent" in a 10-year sample. Kelly also concluded that there was a need for more careful screening of residency applicants and recommended a variety of procedures to aid the "problem" resident.

While the literature cited gives an indication of the interest that exists regarding the problem, there is a dearth of valid statistical information on the nature and scope of emotional illness among psychiatrists in their training years. Recognizing this, a task force of the American Association of Directors of Psychiatric Residency Training was formed in January 1973 to study this matter from a nationwide perspective. It is the intention of this paper to briefly summarize and discuss the findings of that task force.

METHOD

A 68-item questionnaire was designed to provide answers to three major questions: 1) What is the magnitude of the problem? 2) Are there certain characteristics that

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distinguish the emotionally disturbed or failing resident from his colleagues? 3) How do residency programs screen for and respond to the emotionally disturbed or poorly performing psychiatric resident? The questionnaire was designed to obtain data concerning two different groups of residents: 1) those who dropped out, were terminated, or were asked to resign; and 2) those who were able to be maintained in the program despite identified marginal or failing performance and/or severe emotional problems.

The questionnaire was mailed initially to the residency training directors of all the active psychiatric residency programs in the United States and Puerto Rico. Two follow-up mailings were then sent to programs that had not responded to the first inquiry. The mailing list was derived from *A Descriptive Directory of Psychiatric Training Programs in the United States, 1972–73* (8). Combining some programs that responded as a unit, we contacted a total of 251 programs and received 207 usable replies, a return rate of 82 percent. These 207 programs represented 3,737 first- through third-year residents in training for the academic year July 1971 to June 1972. Our sample represented 91.5 percent of the 4,085 residents in training during that period. Child psychiatry and other subspecialty trainees were not included in the survey. The types of programs that composed our sample (i.e., university, state hospital, Veterans Administration, private, etc.) did not differ significantly from the national distribution.

RESULTS

The data indicated that 6.9 percent (N=259) of the total sample of 3,737 residents did not complete the year. Of these 259 residents, 65 percent (N=167) left in good standing, 26 percent (N=68) dropped out or were terminated because of emotional illness, and 7 percent (N=19) left or were terminated primarily because of academic difficulties, with no diagnosis of emotional illness. Five residents left programs for other reasons, including unethical behavior, family demands, or "being angry, hostile, and suspicious." The small size of the groups who left for academic or miscellaneous reasons confirms our impression from experience that residents who exhibit major difficulties severe enough to lead to termination seldom do so independent of emotional disturbance.

Four residents in our survey took legal action in support of their contention that they should remain in their programs; one program reported that this step "frightened and intimidated" the residency committee.

The 68 residents who did not complete their training year due to emotional illness were placed in diagnostic categories as follows: 1) behavior or character disorder —43 percent (N=29), 2) severe neurosis or depression— 35 percent (N=24), 3) psychosis—18 percent (N=12), and 4) death by suicide—4 (3 suicides were originally reported to the survey, and 1 more was brought to our attention after the data were processed). The total of 4 suicides in the 1 year studied gives a crude suicide rate of 106/100,000. To the best of our knowledge, this is the highest rate yet reported for any residency specialty. We have discussed the implications of this disturbing finding in another communication (9).

There were 220 residents who were able to finish the academic year despite marginal performance and/or emotional illness; these represented almost 6 percent of the sample of 3,737. Both this group and the group that terminated because of emotional problems were categorized on 13 background characteristics, and the results are shown in table 1. The two groups differed in three categories—age, history of marital problems, and history of psychotherapy. This emphasizes the need for careful consideration of these three factors in evaluating applicants to residency programs. However, in spite of these differences, the basic similarity between the two groups is striking.

When the results for the combined group of 288 problem residents (those who dropped out because of emotional problems or stayed despite problems) are compared with the few national statistics that are available for the residency population as a whole (10), some interesting observations can be made. In 1971–1972, 27 percent of the national psychiatric residency population consisted of foreign medical graduates. This figure does not differ significantly from the proportion of foreign medical graduates in our problem group (24 percent). Similarly, women constituted 15 percent of the general residency population, which is not significantly different from the proportion in our sample of problem residents (17 percent). Although no current data are available concerning minority group residents, an American Psychiatric Association survey in 1969 (11) found that 24 percent of the psychiatric residency population were members of ethnic minority groups. This compares with a figure of 16 percent for the problem group in our survey. If one assumes a similar national figure for 1971–1972, members of ethnic minorities had a significantly lower incidence of marginal performance and/or emotional difficulties than would be expected by their distribution in the total residency population ($p<.01$). Thus, our results do not support the general belief that foreign medical graduates, women, and members of ethnic minority groups are at higher risk for problems during residency. This observation emphasizes the need for increased openness, information, and understanding in these areas.

The 1970–1971 census of psychiatrists conducted by APA (11) indicated that 42 percent of all psychiatric residents were under the age of 30. Our group of problem residents were significantly younger (63 percent under 30, $p<.01$). Another significant finding relates to transfers between psychiatric residency programs. Based on data from 1969–1970, approximately 6.5 percent of the psychiatric residency population transferred from one program to another in a single year (11). Our sample of problem residents included 12 percent transfers, a significant difference ($p<.01$). This appears to be a definite high-risk factor and raises questions concerning the quality of interprogram communication.

Follow-up data for the 68 residents who did not com-

TABLE 1
Comparison of Two Groups of "Problem" Psychiatric Residents, 1971–1972

Characteristic	Residents Who Did Not Complete Year Due to Emotional Illness (N=68)		Residents Who Stayed in Programs Despite Marginal or Failing Performance (N=220)	
	Number	Percent	Number	Percent
Under 30 years old*	34	50	147	67
History of divorce, separation, or marital problems**	26	38	55	25
Single (no previous marriage)	24	35	59	27
History of psychotherapy	24	35	46	21
Practiced medicine in another specialty previously	16	24	44	20
Graduate of a foreign medical school	14	21	56	25
Female	13	19	36	16
Member of a minority group	11	16	35	16
Emotional problems in spouse	10	15	20	9
Drug or alcohol abuse	9	13	22	10
Transfer from another program (psychiatry)	8	12	27	12
Transfer from another program (other specialty)	4	6	17	8
History of previous psychiatric hospitalization	4	6	5	2

*$p < .02$.
**$p < .05$.

plete their residency year due to emotional illness indicated that 29 percent (N=20) transferred to another psychiatric residency program, 24 percent (N=16) were practicing medicine, 7 percent (N=5) transferred to a residency program in another specialty, 3 percent (N=2) were not practicing medicine, and 10 percent (N=7) were classified as "other." There was no follow-up information for 26 percent of the group (N=18). The large number of residents who transferred to another psychiatric residency program gives the impression of a group of mobile problem residents going from one program to another. Also of concern is the disturbing number of residents for whom no follow-up information is available.

Follow-up on the 220 residents who were able to stay in training despite marginal or failing performance and/or severe emotional problems indicates that three-fourths were urged to go into psychotherapy, but only half did. According to the judgment of the residency directors, 37 percent (N=81) of the residents who were kept in the program performed well, 48 percent (N=106) performed marginally, and 15 percent (N=33) performed badly. These figures indicate that the extra efforts of the residency programs were rewarded in 85 percent of the cases with at least marginal performance on the part of the residents with problems.

The survey also inquired about the applicant screening procedures the various programs used. The most common screening devices "always used" were letters of reference (used by 97 percent of the programs), faculty and staff interviews (87 percent of the programs), medical school records (68 percent), and interviews by residents (52 percent). Only 5 percent of the programs "always or sometimes" used psychological testing. Other methods reported included telephone contact with references, autobiographical sketches, etc. One program reported that it required applicants to interview a patient. Another reported that it obtained letters from past and present psychotherapists. One residency director stated that he talked to pharmaceutical representatives about the applicants.

When asked to rate the usefulness of the procedures they employ, only 30 percent of the programs rated letters of reference and medical records as very useful, although these procedures are virtually always used (see figure 1). The most useful procedures seem to be interviews by faculty members and by residents.

The most widely used evaluative and support procedures in psychiatric residency programs are reports by supervisors and faculty preceptors (see figure 2). Sixty percent of the programs always or sometimes used a resident sensitivity or therapy group. This important technique is the subject of another paper by one of us (12). It should be noted that programs recommended psychotherapy to residents in many instances, although this was not a built-in part of the program.

DISCUSSION

The task facing those who are responsible for psychiatric residency education is a large one. From among a highly successful group of applicants, the residency director needs to be able to identify a potentially disturbed resident before the stresses of psychiatric training precipitate the problem. Then the program needs to identify those individuals in training who are functioning below their potential and who are manifesting emotional problems. When these individuals are identified, the program needs to respond with the decisions, support, and treatment required. It is hoped that increased openness of discussion and further research concerning the problem of the emotionally disturbed and failing resident will make some of these tasks easier.

The problem is indeed great. In the single year of our

FIGURE 1
Psychiatric Residency Programs' Evaluations of Their Screening Procedures for Applicants, 1971–1972

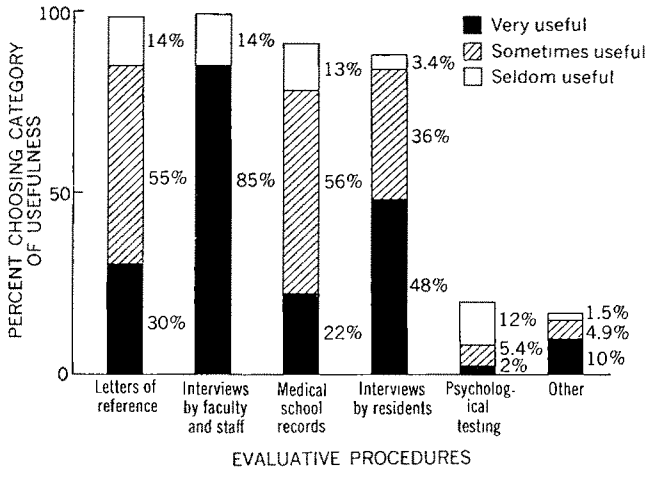
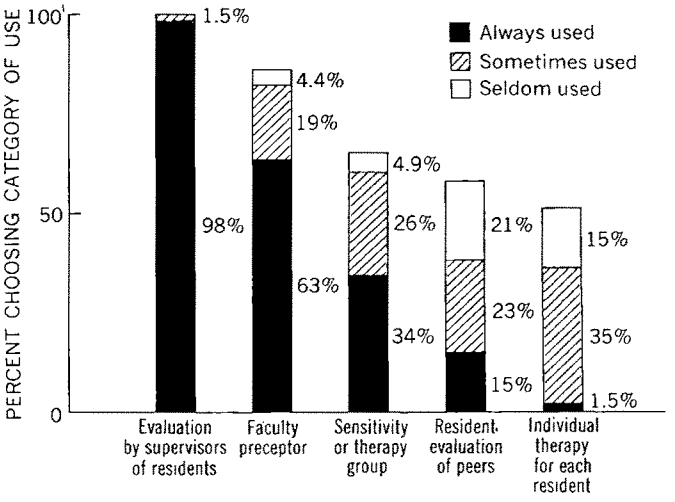


FIGURE 2
Evaluative and Supportive Procedures Used in Psychiatric Residency Programs, 1971–1972



study, 68 psychiatric residents had emotional difficulties of such magnitude that they were unable to complete their residency training. Even more tragic were the 4 suicides and their effects on the other residents and on the institutions involved. More than 8 percent of the residents we studied either did not complete their training because of emotional problems or remained in training despite marginal or failing performance and/or severe emotional illness. This means that a residency program of average size (N = 18 in our sample) will have an average of 1 or 2 residents each year with problems manifested in marginal performance, emotional illness, or (most likely) both. Thus, although Holt and Luborsky's observation (2) that "the great bulk of competent residents (and probably of good practitioners generally) are healthy, conventionally adjusted people" remains valid, the incidence of emotional difficulties among trainees remains a major problem for psychiatric education.

In order to identify the potentially disturbed or problem resident, we need more knowledge concerning the characteristics of residents who are at high risk for difficulties. In comparing our results with the available national data, we found that the incidence of problems among women, foreign medical graduates, and residents from ethnic minority groups was no higher than would be expected on the basis of distribution within the residency population. This finding perhaps will put to rest certain preconceptions, and it again emphasizes the need for more knowledge in this area. Significant factors that we found included a higher incidence of problems among younger residents and those who had transferred from other programs. We are currently gathering more precise data concerning the residency population as a whole in order to make further comparisons possible.

The magnitude and significance of the problem of the marginal resident underscores the need to devote more attention to evaluation procedures. Medical students and others who manifest significant problems should be identified, advised, and helped before they begin their residencies. Our results suggest that personal interviews by both faculty members and residents are the most helpful evaluative procedures and should be part of every resident's screening. Our results also indicate the need to explore other possible means of evaluation.

The high incidence of emotional problems among residents indicates that reliance on screening procedures alone is not enough. It is a common and disturbing experience for residency directors to accept a potentially successful resident who becomes unable to function under the stresses involved in residency training. Our survey indicates that almost all programs employ supervisor evaluations and a faculty preceptor. These practices are to be encouraged. Also of interest is the growing number of programs that employ a sensitivity or therapy group for residents. More research is required to establish the utility of these and other procedures.

Another conclusion that can be drawn from the results of our survey is that a large number of problem residents eventually perform well if they are given the required support and guidance. It is our feeling that this support should include the provision of psychotherapy in many cases. Residency programs may have to assume more responsibility in making this service available.

Our work in this study would be of little value if it did not stimulate thought and concern among those who are responsible for educating the psychiatric resident. In a period in which more and more competent psychiatrists are needed, every psychiatric resident who is unable to complete his training represents a significant loss to society and a waste of long and expensive training. Even more important is the personal loss and tragedy that surrounds so many of these cases. Yet the responsibility for identifying and preventing emotional decompensation goes beyond our own field. As experts in the evaluation and treatment of human behavior, we need to develop

new techniques in the evaluation of our own trainees that will benefit medical education as a whole. The fact that we have been unable to do this adequately so far is the final and perhaps most disturbing conclusion of this paper.

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The Affective Experience of Residency Training in Community Psychiatry

BY PAUL G. COTTON, M.D., AND KYLE D. PRUETT, M.D.

The community setting arouses disturbing feelings (of anxiety, loneliness, anger, and disappointment) within the resident in a manner that is both unique and potentially constructive for his development as a clinician. The examination of these feelings in the supervisory setting and through peer supervision is crucial to the success of the resident's work in the community.

AS THE FIELD OF community psychiatry has matured, some experience in this area has become a recommended part of most approved psychiatric residency programs. In addition, an increasing number of reports on relevant training issues for new practitioners have appeared in the literature (1–3). However, in reviewing the literature on training programs, we have found that relatively little attention has been paid to certain complex and subtle subjective experiences that have a major impact upon the resident's growth and development. These are the affective, intrapersonal issues that are discussed in traditional psychotherapy supervision between supervisor and resident under the heading of "countertransference feelings." In practical terms this usually means the resident's personal reaction to a given psychotherapeutic situation.

We view the community psychiatric experience as a unique opportunity to examine a group of these feelings. In this paper we will outline the setting and supervision of our training experience, describe some of these feelings, give an example of the community experience, and conclude by considering some of the possible long-range effects that the community experience has had on our overall growth and development as clinical psychiatrists.

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THE SETTING

The Tufts Mental Health Center, a part of the Massachusetts system of community mental health centers, consists of an affiliation of 17 agencies already existing in the South Boston-North Dorchester community. At the same time it is an integral part of the training activities of the Tufts Department of Psychiatry, a dynamically oriented training center of Tufts Medical School and the New England Medical Center Hospitals.

Residents in psychiatry spend their first year working primarily on the inpatient psychiatric unit of the Tufts-New England Medical Center Hospitals. During the second year they work with inpatients and outpatients of

Tufts Mental Health Center. The residents work in pairs. For six months one resident is the ward physician on one of three inpatient wards at the Austin Unit of Boston State Hospital, while his alternate works in the area of the community that admits patients to the ward. At midyear the residents switch positions.

It was our community work in the South Boston subdivision of our catchment area that generated our thoughts for this paper.

THE AFFECTIVE EXPERIENCE

The major affective experiences in our community training fall into four categories: anxiety, loneliness, anger, and disappointment. Obviously, these feelings are also central to the traditional psychotherapy situation in which the therapist is called upon to examine these feelings as they arise in his relationship with his patient. However, we wish to call attention to a similar need to acknowledge and examine them in the community experience, although the nontraditional roles and settings here can make this analysis more difficult. Just as the failure to acknowledge and work through these feelings can lead to an inappropriate disruption in a psychotherapeutic relationship, it can also lead to misunderstandings and unnecessary failures in community efforts.

The anxiety we are discussing was specifically related to the ambiguity that characterized the community training experience. This ambiguity was particularly striking when we contrasted it with our experience in a traditional inpatient setting where patients, clearly defined as such, came with complaints to us as residents in psychiatry. In community settings it is rarely as clear who is the patient, what is the role of the physician, and what constitutes treatment and improvement or cure. The ambiguity in the role of the physician extended from our vague perception of what skills we had to offer to the confused expectations of the people with whom we would work in the community.

Loneliness was experienced because the community work itself was often done in relative isolation from other medical colleagues and away from the main hospital facilities. We especially felt the loss of a shared sense of purpose with our colleagues. We missed our teachers in the office nearby. There was no such thing as a "coffeepot consultation."

Our anger was aroused by the suspicion and skepticism that we encountered in the people we met. They questioned our motives, reliability, and usefulness and distrusted even our "sacred" position as helping professionals. We were angry at this challenge to our professional self-images.

A final issue is the particular kind of disappointment we experienced, which stems from the nature of the community work itself. First, our fantasies of both the amount and quality of work we hoped to accomplish were clearly not met. Second, it is necessary to perform much more trial-and-error, preparatory work in a community setting than in the more defined, structured setting of the hospital. Initially, we felt that much of our time and effort was not productive. We felt fallow.

SUPERVISION

We now turn our attention to the role that two modes of supervision played in facilitating our awareness of the feelings previously described. The first was a traditional supervisory meeting held weekly between each of us and our clinical supervisor, a full-time member in our department who had had significant experience in community psychiatric work. These sessions dealt primarily with the more technical aspects of the consultation rather than the more subjective issues previously discussed. Although it is not the focus of this paper, we had a great deal to learn about the principles and mechanics of consultation. This learning took place primarily in the traditional supervisory sessions.

The second mode of supervision developed out of our working relationship, which was fostered by the structure of the residency program that paired the second-year residents. In order to establish some continuity between our experience on the ward and in the community, we scheduled a formal weekly meeting in which we discussed aspects of the community psychiatry experience. These meetings continued through the year regardless of which of us was working in the community. We noticed that these meetings evolved into discussions of our more personal reactions to the community work. We discovered that our personal reactions came up more fully and more frequently in these meetings than in our traditional supervisory meetings.

There were some obvious problems in our traditional supervisory meetings. Not only do residents often pay selective attention to those areas in which they do well, but also their ability to talk with a supervisor about interpersonal concerns varies widely with each resident-supervisor mix. Two residents who have known and worked with each other for more than a year have the potential for a trusting relationship that can allow access to their positive as well as negative personal reactions to their work. Most concretely, in this case we found it easier to tell each other that we were at different times anxious, lonely, angry, or disappointed. It was very valuable for our personal growth as well as for the success of our work to discover and examine the common situations that led to these feelings. In retrospect this seemed crucial to the success of the community consultation.

THE AFFECTIVE EXPERIENCE IN THE COMMUNITY

We selected the following case from our community experience in order to illustrate the affective experiences previously outlined.

After discussion with our staff supervisors, we decided to attempt to develop a consultation with the large urban high school located within our catchment area. At that time there was no formal consultation with the school;

however, its staff had expressed an interest in receiving some help from the mental health center. During the summer one of us (P.G.C.) visited the school to speak with the headmaster, the assistant headmaster, and the master in charge of the ninth-grade annex. At that time he introduced himself and expressed an interest in the possibilities of working together. He was received with some skepticism. The headmaster described how previous mental health workers had been more interested in their own training than in helping the high school. Another story was told about a group of mental health workers who had stopped coming to the high school when their own research project was finished. Despite these feelings the group offered to meet again at the beginning of the school year.

At that point in the first meeting it seemed that the school staff had accepted the offer to work together, and the resident became more active. Responding in part to the group's skepticism, he defined his time commitment—approximately one morning each week during the school year—and suggested that the group and he decide together what work could be done during that year. This gave a focus for the first meetings, allowed him to remain flexible, and gave him the opportunity to discover the main problems of the school as presented by the staff. As he left this meeting the resident felt good about the prospects for the fall.

The resident returned to the high school shortly after the beginning of the school year. Finding the front door locked, he rang the bell, and a teacher who had been sitting at a desk behind the door asked him who he was and what he wanted. After he introduced himself, she asked him for identification to prove that he was a physician working for the mental health center. She then telephoned the assistant headmaster's office and asked permission for him to enter. He was then admitted to the building.

He walked into the headmaster's office, which was crowded and obviously very busy. He announced his arrival to the secretary, who asked him to be seated. After he had waited for some time he was seen by the assistant headmaster, who said he was very busy since it was the beginning of the school year. The assistant headmaster suggested that the resident return the following week since he did not have anything specific to talk about with him. A similar series of events took place at the next two meetings.

After several mornings of this, the resident began to get angry. Different teachers were assigned to the front door of the school on a rotating basis. They were all suspicious, probably based on their unpleasant experiences with outsiders coming into and disrupting the school. This was the first time during his residency that the author had been mistaken for an interloper. He commented to his colleague that there might be more truth in this message than he was willing to admit.

At this point he was also disappointed. He had spent several mornings working in the community, and he still had difficulty getting in the front door. His anxiety was heightened by the continual lack of defined tasks. In contrast to his expectations, he had accomplished very little. He was also very lonely. He sensed that he was not wanted. The "enemy" was all around him. There were no friendly supervisors in the next office with whom to share these feelings. It seemed that the isolation of the setting heightened his feelings of anxiety, anger, disappointment, and loneliness.

It became clear in our discussions with each other that the recognition and understanding of these feelings were the prerequisite for our further work with the school. If the feelings had been projected onto the school, which was seen as rejecting, our efforts could have floundered. When we accepted the feelings as our own and began to explore them, we were able to develop means of dealing with the difficulties. For example, we planned to deal with the staff's suspicions by having the resident currently working with the school introduce himself to the teachers and guidance counselors, talking with the school nurse, and continuing to appear each week. We wanted to show them that their fears of him were unfounded. As he confronted the suspicion, the loneliness became less of a problem. By the fourth week the assistant headmaster was talking with him and the teachers and guidance counselors began to greet him when they saw him.

Eventually, over a period of about three months, he was able to apply his clinical skills. The assistant headmaster focused on behavior problems. The guidance counselors consulted him about difficult emotional problems. Occasionally, when a teacher was interested in making a particular point about mental health, he would ask the resident to sit in on the class. Then the resident discussed the presentation with him. From time to time he saw individual students. The other resident (K.D.P.) enjoyed a similar relationship with the staff.

There is a large body of literature on school consultation (4–8). Many of these observations were useful to us in the later aspects of our work in the school. However, we must reemphasize that the success of this work was dependent upon the attention we paid to the feelings generated in our initial contacts with the school.

CONCLUSIONS

Our experience in the community has given us the opportunity to acknowledge and analyze some of the differences between working in that setting and in the traditional mental health institutions and to examine some of our feelings when presented with these differences. We have found that the analysis of these feelings was crucial in terms of the effectiveness of our community work and was relevant to our personal growth as clinicians.

The process of doing community work and reflecting on it is a response in some sense to the professional drives toward independence and competence. The clinician can learn in another setting the importance of careful analysis of the nature of clinical material as it emerges both from himself and from the problems particular to community work.

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Controversies in Psychiatric Education: A Survey of Residents' Attitudes

BY JOHN F. GREDEN, M.D., AND JORGE I. CASARIEGO, M.D.

The authors administered a questionnaire including statements regarding controversies in psychiatric education to 86 residents in six programs in the Washington, D.C./Baltimore, Md., area. The residents were asked for their opinions on educational policies, ideological issues in psychiatry, their identification with traditional areas of medicine, and future regulatory practices for psychiatry. The data gathered show some shifts in attitudes among first-, second-, and third-year residents. They also show a marked inclination toward dynamic-analytically oriented psychotherapy. The authors conclude that substantial changes will be required in the core curriculum of residency education if the prediction that tomorrow's psychiatrist will be a complete psychobiologist is to be fulfilled.

PSYCHIATRISTS ARE STRUGGLING with a multitude of controversies pertaining to such diverse issues in psychiatric education as the need for internships (1), the benefits of psychotherapy during residency (2), the desirability of the medical model or liaison with neurology (3–8), the value of social activism by psychiatric organizations (9), the relative merits of various therapeutic modalities and the ideologies on which they are based (10), the wisdom of periodic recertification (11, 12), and the future importance of psychoanalysis and neurochemistry (13).

The perceptions of psychiatric residents regarding these issues are important for a variety of reasons. First, residents are the consumers of our educational policies; as such, their perceptions may provide quality control information about the type of product our medical schools are turning out. Second, residents constitute a numerically substantial and outspoken segment of the profession; their support for contemplated changes in educational policies can be crucial. For this reason, and because residents appear more formative and flexible than established practitioners, rhetorical arguments often seem to be directed their way.

Third, residents are the future leaders of the profession. There is no guarantee that their viewpoints will remain stable in ensuing years, but residents' perceptions today may provide clues as to where psychiatry is headed tomorrow. For these reasons, we sought to determine how psychiatric residents in one part of the United States perceived some of the philosophical-methodological controversies being discussed at all levels of psychiatry.

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METHOD

In May and June 1973, we personally administered questionnaires to 86 psychiatric residents in six residency programs in the Washington, D.C./Baltimore, Md., area. The 86 respondents represented 77 percent of all residents enrolled in the six programs. Eight of the residents

were at the Bethesda Naval Medical Center, Maryland (all of the residents in that program); 4 (67 percent of the program) at Freedman's Hospital/Howard University, Washington; 24 (63 percent) at Georgetown University Hospital, Washington; 7 (88 percent) at George Washington University Hospital, Washington; 17 (65 percent) at Sheppard and Enoch Pratt Hospital, Towson, Md.; and 26 (96 percent) at Walter Reed Army Medical Center, Washington. The educational policies of these programs have been described recently (14).

The residents whom we were not able to survey were, in most instances, on vacation, scattered to elective programs in other facilities, or busy when the questionnaire was administered. Twenty-six of the residents surveyed were in their first year, 31 in their second year, and 29 in their third year of training. Participation was voluntary, anonymous, and confidential; cooperation was generally excellent. No forms had to be discarded because of inadequate completion.

The questionnaire was a computer-tabulated, 21-page form with 120 items. It inquired about the resident's demographic and educational background, perceptions of the residency program in which he or she was enrolled, and whether he or she was receiving individual psychotherapy. Personal experience with various treatment modalities and ratings of these treatments occupied the major part of the form. (This information will be presented in another paper.) Thirteen questions dealt with controversies in psychiatric education. Responses to these items are the subject of this paper.

All statements that dealt with a controversy in psychiatric education were answered by means of a five-point Likert scale (15). The possible responses ranged from strong disagreement to strong agreement. Responses among residents in each of the three years of training were compared.

TABLE 1
Demographic Characteristics of 86 Residents

Characteristic	Percent of Residents Having Characteristic			
	All Residents (N=86)	By Year of Residency		
		First (N=26)	Second (N=31)	Third (N=29)
Under 29 years old*	39	65	32	21
Men	87	85	90	86
White	87	80	93	86
Married*	73	65	73	78
Did not have internship*	22	42	19	7
Religious heritage				
Protestant	28	31	32	22
Catholic	39	31	36	50
Jewish	26	31	25	21
Other	7	7	7	7
Not currently active in religion	67	62	74	64
Received personal psychotherapy before residency	28	23	29	32
Received personal psychotherapy since residency*	43	35	42	52
Self-rating of psychiatric orientation				
Dynamic-analytically oriented	62	65	65	57
Eclectic	33	23	32	43
Miscellaneous**	5	11	3	0

*$p<.05$ by chi-square analysis. The variables tested were: under 29 years old versus 29 years old and older; married versus single, separated, or divorced; having had an internship versus not having had one; and having received personal psychotherapy since residency versus not having received psychotherapy since residency.

**This category included behavioral, biological/organic, and community psychiatry.

RESULTS

Demographic data for the total group and for residents in each year are given in table 1. Several observations about demography were noteworthy. A much higher percentage of first-year residents did not report having had an internship. Religious activity was absent among most residents, and 28 percent reported that they had received psychotherapy before residency. Perhaps most important for considering residents' opinions in context, respondents in this population reported a conclusive predilection (62 percent) for a psychotherapeutic orientation.

Ratings of controversial issues are given in table 2. The initial controversy we inquired about was the internship dilemma. Forty-six percent of the 86 residents agreed that internship should be required before psychiatric residency; 39 percent disagreed. Not surprisingly, every supporter of the internship had taken one himself. Conversely, all those who had not taken internships (22 percent of the total population surveyed; see table 1) opposed the idea of requiring one. Since 42 percent of the first-year residents had personally avoided the internship year, a substantial proportion of the opposition was expressed by the first-year group ($p<.05$ by chi-square test).

Psychiatry's relationship with other branches of medicine was approached from several perspectives. First, respondents were asked about their own medical identity. The majority (58 percent) disagreed with the statement that they were a psychotherapist first and a physician only second. Despite this apparent support for a physician's identity, however, there was a coexisting disavowal of the traditional doctor's role of physically examining patients. Sixty-one percent of the residents disagreed with the statement that psychiatrists should conduct physical examinations on patients they plan to treat psychiatrically. Sixty-seven percent also felt psychiatrists should not perform rectal or vaginal examinations on their patients. These beliefs had apparently been present before residency or had developed early in the residency because first-year residents were identical to their second- and third-year colleagues in voicing little support for the role of physical diagnostician.

When asked to rate the statement that the medical model is outdated, one-third of all respondents agreed with this assessment. Interestingly, 57 percent of first-year residents disagreed with the idea that the medical

TABLE 2
Residents' Responses to Statements Regarding Psychiatric Controversies (N=86)

Statement	Residents' Responses in Percents: Strongly Agree or Agree	Neither Agree nor Disagree	Strongly Disagree or Disagree
Internship or its equivalent should be required before residency	46	15	39
My current identity is that of a psychotherapist first and a physician only second	26	16	58
Psychiatrists should personally conduct physical examinations on patients they plan to treat psychiatrically	13	26	61
Psychiatrists should not perform rectal or vaginal examinations on patients they plan to treat psychiatrically	67	17	16
The medical model of mental illness is definitely outdated	33	21	46
Psychiatrists in training should be required to rotate through a state mental hospital	23	24	53
All psychiatrists should conduct a research project before completing their residency	23	31	46
Compulsory periodic recertification of psychiatrists should be instituted (e.g., every five years)	49	27	24
Psychiatrists should not be required to take neurology examinations for board certification in psychiatry	47	4	49
Official organizations representing psychiatry (e.g., APA) should become more active in publicly recommending solutions for such social problems as racism, war, and poverty	48	12	40
Psychoanalysis is dying as an influential part of psychiatry	7	10	83
In the future, neurochemical discoveries will dramatically change psychiatry toward a medically oriented specialty	28	29	43
Psychiatrists are extremely susceptible to fads in considering new treatment approaches.	26	25	49

model is outdated compared with only 44 and 32 percent, respectively, of the second- and third-year groups ($p<.05$ by chi-square test).

Since criticism has been expressed about maldistribution of psychiatrists, residents were asked whether they felt state hospital rotations should be required during residency. There was clearly little support for this policy. Responses differed significantly, however, among first-, second-, and third-year residents. Only 35 percent of the individuals in their first year of training disapproved of state hospital rotations compared with 57 percent of second-year respondents and a startling 72 percent of third-year residents. There was also little approval expressed for the requirement of research activity during psychiatric residency.

Two items on the form dealt with certification policies. Almost half of all respondents agreed with compulsory periodic recertification; 24 percent disagreed. Most of those who disagreed were third-year residents. On the second certification issue, the 86 residents split almost evenly when asked whether psychiatrists should continue to be required to pass a neurology exam for board certification in psychiatry. Forty-seven percent felt this requirement should be dropped and 49 percent advocated continuation. Differences were again apparent according to year of residency. Only 22 percent of the first-year residents felt that neurology should not be required compared with 57 percent of second-year and 62 percent of third-year respondents ($p<.01$ by chi-square test).

A variety of miscellaneous statements were also rated by the 86 residents. Social activism on an organizational basis, e.g., through official policy statements of APA, was approved by 48 percent but disapproved by 40 percent of the residents. No differences were found among first-, second-, and third-year respondents for this item. The intensity of feeling on this issue was reflected by the fact that 15 percent strongly agreed and 16 percent strongly disagreed.

The one expression of relative unanimity among this group of residents occurred in response to the statement that psychoanalysis is dying as an influential part of psychiatry. Eighty-three percent of all respondents supported analysis in their ratings of this statement. A meager 7 percent appeared ready to sound the death knell of analytic influence. In rather stark contrast to this support for analytic approaches, only 28 percent of all the residents agreed with the statement that neurochemical discoveries will alter the future practice of psychiatry.

When asked whether they felt psychiatrists are susceptible to fads when considering new treatment approaches, 49 percent of the residents disagreed. However, this was still less than a majority. Twenty-six percent of the respondents agreed with this blatantly critical statement of treatment trends in psychiatry.

Residents were also asked to rate the importance of personal psychotherapy in becoming a good psychiatrist. Their responses to this item are shown in table 3. More than half of all the residents considered it extremely important and 29 percent rated it moderately important. Nineteen percent considered it minimally or not important. Predictably, every resident who rated therapy unimportant was not receiving therapy. Less predictably, but still consistent, all residents receiving therapy rated it either moderately or extremely important.

DISCUSSION

The topics evaluated in our questionnaire did not focus upon a single theme. Rather, they pertained to educational policies for residents, ideological issues plaguing psychiatry, identification with traditional areas of medicine, and future regulatory practices for the profession.

Several trends were identified. When the total sample

was considered, the majority of residents disagreed with any policy that would require research projects or state hospital rotations during residency. They disagreed with the concept of psychiatrists' conducting physical examinations, especially rectals or vaginals, on patients they treat psychiatrically. They did not foresee that neurochemical discoveries would change psychiatry and denied that psychoanalysis was dying as an influential part of the profession. Many residents supported reinstitution of the internship, but only if they had taken one themselves. Almost one-half supported compulsory periodic recertification, but one-half also wanted to eliminate neurology from the certification examinations for psychiatry. Social activism by official organizations of psychiatry was supported by 48 percent of the residents but disapproved by 40 percent. Psychotherapy was generally rated an important part of residency education.

This study was not a longitudinal assessment of the same individuals throughout their residencies, but several apparent shifts can be cautiously observed when first-, second-, and third-year residents are compared. A higher percentage of those nearing the end of their training were against state hospital rotations, against compulsory resident research, against inclusion of neurology in psychiatric certification examinations, and against compulsory periodic recertification. Third-year residents also expressed less support for the medical model and for the future importance of neurochemical discoveries.

Conceivably, residents in the later stages of training may have responded differently because of increased experience or knowledge. It would be difficult to justify their greater skepticism toward neurochemical discoveries on a scientific basis, however. Most of the items we assessed were subjective; there is little significant documentation to support one view or another. We therefore conclude that the opinions expressed by residents in each year of training were formulated largely through a process of unscientific extrapolation dependent upon the resident's psychiatric set or ideological identity.

Longitudinal evaluation would be required for definite confirmation, but we would speculate that as the resident's ideological identity changes during residency, his opinions regarding controversial issues are modified to conform. In this context, it is noteworthy that more than 57 percent of residents in all three years described themselves as dynamic-analytically oriented and that, although 33 percent of all residents described themselves as eclectic, these individuals differed from analytically oriented respondents only in their greater acceptance of behavioral therapy techniques. Eleven percent of the residents in their first year of training categorized themselves as oriented toward behavioral, biological/organic, or community psychiatry, but among second-year residents only 3 percent adhered to this identity; none of the third-year respondents described themselves with these labels.

Armor and Klerman (16) classified psychiatrists into psychotherapeutic and somatic. According to this distinction, a startling 95 percent of residents in our survey would be categorized as more or less psychotherapeutic. If the predominance of this psychotherapeutic ideology is taken into consideration, the responses reported on controversial issues are generally more understandable.

TABLE 3

Perceptions of the Importance of Personal Psychotherapy in Becoming a Good Psychiatrist Among 86 Residents

Rating of Importance of Psychotherapy	Percent of Residents Giving Rating			
	All Residents (N=86)	By Year of Residency		
		First (N=26)	Second (N=31)	Third (N=29)
Extremely important	52	54	48	54
Moderately important	29	27	29	32
Minimally important	8	8	13	4
Not important	11	12	10	11

Caution must be taken, of course, in generalizing these findings to residents in other parts of the country. The Washington/Baltimore area has a long-standing tradition of emphasizing psychotherapy. Ideological approaches elsewhere may be substantially different. If so, perceptions of controversial issues might also be different.

West (1) described the psychiatrist of tomorrow as "more of a neurobiologist, more of an endocrinologist, and more of a behavioral scientist than the psychiatrist of today." Similarly, Myers (17) referred to the psychiatrist of tomorrow as the complete psychobiologist. These formulations for the future are obviously not being adhered to by the majority of the residents we surveyed.

Paradoxically, five of the six programs assessed in this study generally described themselves as eclectic in the *Descriptive Directory of Psychiatric Training Programs* (14). Yet when residents' attitudes, experiences, ideological orientations, and ratings of treatment modalities were considered, it appeared illusory to consider the products of these programs as being truly eclectic. Most were clearly psychotherapeutic at the time of the survey.

We suggest that psychiatric residents have a propensity to drift toward endeavors that they find enjoyable or compatible with their ideological set; global manpower considerations and scientific data seem to exert little influence in career directions. If the production of complete psychobiologists is truly the professed goal of residency education programs—a viewpoint that certainly lacks universal agreement—the unpleasant reality appears to be that this goal can be reached only after program directors establish rigid core curriculum standards that all residents must adhere to. Most residents—at least in the Washington/Baltimore area—do not appear inclined to choose the exacting course described by West and Myers.

It might be worthwhile for program directors to assess and publish the orientations and types of practice their graduating residents have selected (18). Such data might furnish incoming applicants with a more accurate appraisal of residency programs than published statements of intent do. Such studies might also generate precise data to embellish planning sessions about future trends in psychiatric education.

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Attitudes of Psychiatric Residents Toward the Necessity of Internship

BY TOKSOZ B. KARASU, M.D., STEFAN P. STEIN, M.D., AND EDWARD S. CHARLES, M.A.

The authors note that the elimination of the internship requirement for board certification has engendered much discussion and has called attention to the need for further study of training in psychiatry. To help clarify the issue, they investigated demographic and career choice factors, individual internship decisions, and perceptions and feelings about these decisions in 57 psychiatric residents. The results indicate that the career plans of students have a strong influence on their training choices—those who are oriented toward inpatient psychiatry and psychosomatic medicine view the internship as more relevant than those who plan to concentrate in other areas. The authors suggest further research on the relation between career choice and training preferences.

PSYCHIATRIC education has recently become the subject of study and controversy. As they have moved into the mainstream of university medical settings in recent years, psychiatric training programs have reflected changing trends in the field of psychiatry.

The 1940s and 1950s were marked by a great emphasis on dynamic psychiatry. Psychoanalytic psychology became integrated into the body of psychiatric knowledge and psychoanalysts brought their expertise to many training programs. In the 1960s, social and community psychiatry added another dimension, paralleling changes in American medicine at large. In addition to teaching the "technology" of psychiatric practice, many other issues were raised, such as health care delivery, coordination with other caretakers, and consumer participation. Most recently, advances in neurochemistry and neuropharmacology have not only increased scientific curiosity among psychiatrists but have also created a renewed "medical" outlook for the future of the profession.

One may speculate that a "return to medicine," if one may use that designation, would tend to further the influence of general medicine on psychiatry. In eliminating the requirement of internship for certification, the American Board of Psychiatry and Neurology was following the pattern of other medical specialties. The decision to permit direct entry from medical school into residency

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training programs has engendered a great deal of discussion and opinion. Some educators have warned that the quality of the education of the future psychiatrist may be adversely affected, while others feel that psychiatrists may be well-trained without a formally designated internship (1, 2). However, few studies have addressed these issues in a systematic way.

In an earlier study (3), we compared the work of internship-trained first-year residents with that of a matched noninternship group on a psychiatric inpatient service. A chart review comparison revealed differences in patient care practices in the areas of length of stay, writing of progress notes, and use of the laboratory and of medical consultants. Staff ratings of the two groups of residents were found to differ significantly on four of five categories. The data from this study suggested that residents without internships were at somewhat of a disadvantage in their work in this inpatient setting. Internship appeared to improve the resident's ability to handle certain medical-psychiatric aspects of inpatient care.

The question may be raised whether the differences we noted in that study may diminish in later years of residency training and whether there will ultimately be any measurable differences between the two groups. In addition, that study was conducted on an inpatient service, and the results may not be generalizable to other types of psychiatric practice, such as community psychiatry or outpatient psychotherapy. The relevance of the internship may depend in part on later career interests of the particular resident.

This paper reports a systematic attempt to examine the attitudes of a group of residents toward the elimination of the internship. While we are emphasizing the future career plans of the residents, their backgrounds and personal characteristics were also studied.

METHOD

The study was conducted on the psychiatric service of the Bronx Municipal Hospital Center, Bronx, N.Y. The psychiatric residency program of the Albert Einstein College of Medicine of Yeshiva University has been staffing this service since its inception in 1955. There are approximately 18 residents in each year of training. The first year is spent on the inpatient service of the Abraham Jacobi Psychiatric Unit, Bronx Municipal Hospital Center.

The second and third years are spent in the outpatient department, which consists of adult and child-adolescent clinics. A variety of treatment approaches are taught, ranging from group-milieu approaches to long-term individual insight therapy to the use of psychoactive drugs and other somatic therapies. Rotating consultation to other medical services is part of the first- and second-year assignments.

A full program of seminars related to the study and treatment of individuals, families, and groups complements the resident's supervision and clinical work. Current theories of causation of the major psychiatric illnesses are presented in an atmosphere of eclectic learning. The curriculum is similar to that of other major East Coast psychiatric programs in its approach to training and patient care. The residency program began to accept residents without an internship in 1970.

All residents in the program (N=62) were asked to complete a comprehensive survey regarding attitudes toward the internship in psychiatric education. The survey also investigated social and demographic characteristics and career plans of the residents. Open-ended questions inquired into reasons for residents' individual choices of internship versus no internship and their perceptions of the effects of this decision (if the option had been available to them).

RESULTS

Of the 62 residents in the program, 57 (94 percent) completed the survey. Fifty of the respondents (88 percent) were internship-trained residents and 7 (12 percent) were noninternship-trained residents. Table 1 presents demographic data and career plans for the 57 respondents. Eighty-one percent of the residents were men and 19 percent were women. Their ages ranged from 26 to 38, with no significant distribution differences between the internship and noninternship groups. Two-thirds of the residents were married. The career plans of almost all of the respondents included private practice and teaching; 6 residents (11 percent) planned psychosomatic medicine liaison work.

On the attitude survey (see table 2), 69 percent of the respondents agreed with the statement that an internship should be a prerequisite for psychiatric residency. Of the 25 percent who strongly agreed, all were in the internship

TABLE 1
Characteristics of Psychiatric Resident Respondents (N=57)

Characteristic	Number	Percent
Sex		
Male	46	81
Female	11	19
Age		
26–27	12	21
28–29	26	46
30–31	11	19
32–33	6	11
36–38	2	3
Marital status		
Married	38	67
Single	15	26
Separated or divorced	4	7
Internship		
Yes	50	88
No	7	12
Career plans		
Private practice	55	96
Teaching	56	98
Psychoanalytic training and practice	24	42
Research	19	33
Community mental health	13	23
Psychosomatic medicine	6	11

TABLE 2
Residents' Responses to a Survey of Attitudes Toward Internship, in Percents (N=57)

Item	Disagreement	Slight Agreement	Moderate Agreement	Strong Agreement
1. An internship should be a prerequisite for psychiatric residents.	31	18	26	25
2. An internship is totally unnecessary as preparation for psychiatric residency.	63	14	19	4
3. An internship is an asset, but not essential, in preparation for psychiatric residency.	18	10	25	47
4. Psychiatrists should not attend medical school, but should be prepared in a special interdisciplinary graduate school program, with emphasis on psychobiological and social sciences.	37	25	22	16
5. If you were presently a third-year medical student and planning a psychiatric residency, would you take an internship?	No—37		Yes—63	

group, while all of the noninternship group were among the 31 percent who disagreed. Thirty-seven percent agreed with the statement that an internship is totally unnecessary, while 82 percent agreed with the statement that an internship is an asset but is not essential in preparation for psychiatric residency.

The statement that psychiatrists should not have to attend medical school was answered "strongly agree" by 16 percent of the residents, all of whom had internship backgrounds. Among the 36 residents who stated that they would take an internship if they were third-year medical students now, there were 2 who had elected not to take an internship.

Responses to the open-ended questions of the attitude survey generally identified greater ease in medical management and increased self-confidence in the role of physician as benefits accruing to the beginning psychiatric resident from internship. Sample comments excerpted from responses of the internship group to the open-ended section of the questionnaire include the following:

"More comfortable with responsibility for patient care and more confident in my role as a doctor."

"My beginning residency was less of a stress; internship helps speed clinical maturity."

"Without an internship, you're not a real doctor."

From the noninternship group came these comments:

"I felt slightly less prepared and less comfortable with patient responsibility."

"Did not feel confident in my ability to make medical decisions at the beginning."

"Having had it would have made moonlighting possibilities greater."

Most of the comments from both groups were consistent with these examples.

DISCUSSION

The effect of elimination of the internship may be quite different for psychiatry than for other medical specialties. The type of experience gained during an internship is often contained within the first year of residency in other medical specialties. Residency training in psychiatry may not similarly compensate for the absence of the internship year. For residents in psychiatry, bypassing the internship phase may have a different implication regarding their interest in and attitude toward medicine, as well as their future career direction. Thus direct entry into a psychiatric residency may have not only a "telescoping" effect but also a divergent effect that encourages early departure from a medical orientation.

There is a broad spectrum of practice opportunity within psychiatry, ranging from medical and biological research and hospital practice to social and community psychiatry. Career plans within the field of psychiatry may define the usefulness of the internship experience. This study focused on the relationship of specific career plans to the decision whether or not to take an internship.

All noninternship residents disagreed that an internship should be a prerequisite for psychiatric residency, although 2 of them stated that they would take the internship if they were currently third-year medical students. This option was, of course, available to them, and they elected not to do so. Thus, the fact that the internship is not mandatory may lead to the prospective resident's belief that it is not useful or necessary. Some noninternship residents indicated that they would have taken an internship in spite of their views that internship should not be a prerequisite. Such conflicting statements may reflect a negative attitude toward requirements in educational institutions that may be prevalent. On the other hand, 21 of the respondents (advanced residents who had not had the option of direct entry into residency) stated that in retrospect they would not have taken an internship if they had had a choice, even though they all viewed the internship as a valuable experience.

Valuable experiences may not necessarily be viewed as desirable. In addition, as a resident advances and becomes more distant from the care of the acutely ill psychiatric inpatient, his view of the relevance of an internship may be modified by that distance and by the development of a new professional identity, that of "psychiatrist." All of the 6 residents (11 percent of the sample) who planned a career in psychosomatic medicine were among those who had taken internships and who reported on the survey that they would make the same choice again.

The career choice of all of the noninternship residents

and 37 percent of the internship residents excluded psychosomatic medicine and research. This segment of the internship residents was among those who agreed with the statement that they would not have taken an internship if they had had the option. Their future career plans were directed toward psychotherapy, teaching, and community mental health work. Thus, the career direction of the resident appears to influence his view of the usefulness of the internship, as well as his decision whether or not to take it.

The data suggest that career plans play an important role in determining the type of training an individual arranges. An internship is viewed as particularly relevant by those who plan a career in psychosomatic/liaison medicine or inpatient psychiatry. The relevance of an internship for those whose career plans include outpatient psychotherapy or community psychiatry is an open question. Further study exploring the relationship of career choice to training in psychiatry is needed.

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Career Decisions in the Early Postresidency Years

BY JAMES L. CAVANAUGH, JR., M.D.

The author notes that the end of the postresidency military obligation necessitates earlier career decision making for the senior psychiatric resident. This problem is seen to be exacerbated by the eclectic nature of most psychiatric training. Issues for residents include the problem of role models and the "senior resident syndrome," the decision of whether to maintain their university affiliation, the role of private practice, questions of clinical maturity, etc. The author believes that programs must be developed to systematically and objectively present to residents the data that now exist regarding multiple career options.

WITH THE disappearance of the postresidency military obligation, the senior psychiatric resident is forced to make decisions on career directions at an earlier time than ever before. Whereas some form of government service (e.g., military, Public Health Service, or Veterans Administration) has traditionally given the majority of newly trained psychiatrists two additional years of structured clinical, administrative, or research opportunities, the termination of the doctor draft, the CORD program, and the Berry plan will now present all senior psychiatric residents with a similar dilemma—what to do professionally in the early postresidency years. For the university-based, eclectically trained resident—a description that fits a majority (54 percent) of all residents (1)—decisions about career directions are particularly difficult. Assistance in exploring these questions has not classically been a significant function of the medical-school-based residency experience, and the majority of newly trained, eclectic psychiatrists have heretofore used government service as a period for debating, reflecting, and decision making about future goals.

Numerous studies (2–6) over the years have explored the diverse issues involved in the process of residency training. Relatively little study has been devoted, however, to the issues raised by the early postresidency years and the problem of multiple choices for career direction. It is imperative that departmental chairmen and directors of residency training programs begin to explore more fully ways to help all psychiatric residents deal with these crucial early postresidency decisions about career directions. This paper will explore various issues raised in career decision making for the eclectic resident.

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ROLE MODELS AND THE "SENIOR RESIDENT SYNDROME"

Role modeling after mature psychiatric teachers clearly has a very powerful influence on resident behavior and professional identification. Brody described the process as

> the unconscious acquisition (following some conscious imitation) of some of their ways of thinking, feeling, and acting. Such identification and its eventual dissolution, leaving key residuals integrated with precipitates of other important relationships, is an essential aspect of the maturation process without which learning is merely the cross-sectional reception of information. (7, p. 155)

For today's eclectic resident, the predominant role model remains the "triple-threat" psychiatrist (clinician, teacher, and research professor) originally described by Sharaf and Levinson (8). Exposure to these career sets, exemplified by the most prestigious academic psychiatrist, at crucial times during their development creates for the majority of psychiatrists in training an awesome professional goal. Many (perhaps most) senior residents are uncomfortable with this complex role model or feel inadequate to live up to it. Understandably, these individuals experience anxiety, confusion, and even depression as the time for career decision making approaches. To make a mature decision, they must reexperience old conflicts about role confusion initially struggled with as part of the beginning psychiatry training syndrome (9). At best, the triple-threat role model has only been partially assimilated and mastered, or partially rejected and other models incorporated. Professional identity versus professional identity diffusion, analogous in part to the crisis in adolescent development described by Erikson (10), characterizes what may well become a new syndrome—the "senior resident syndrome"—created by the eclectic dilemma and accentuated by the termination of two years of required postresidency military experience. Finally, the eclectic psychiatrist, as recently reviewed by Abroms (11), has no theoretical framework to replace the integrative function of psychoanalytic theory. Career preceptorships and special seminars must be developed in eclectic residency programs to help all residents explore more fully the complex personal and professional issues raised by the senior resident syndrome and the role model of the academic psychiatrist.

CLINICAL MATURITY AND THE RETREAT FROM THE PATIENT

University-based residency programs have emerged as the most prestigious centers for psychiatric training. This academic and research orientation in residency training has dramatically expanded the data base of the eclectic psychiatrist and has resulted in greater respectability for psychiatry within the university medical center. Kubie, however, recently called attention to an alarming pattern developing in academic centers of medicine.

> It is a disease without a name whose presenting symptom is a retreat from patients. . . . The flight from patients is even better rationalized, culturally supported, and to a dismaying degree practiced, defended, and approved by many eminent psychiatrists. (12, p. 101)

For the bright young man in a hurry academically, the triple-threat role model is perhaps an appropriate one, but its contribution to the continuation of the development of clinical maturity is more dubious. Clinical maturity still remains the cornerstone of psychiatric judgment, and Kubie further stated that if the eclectic is to be well trained, "He must first become a psychiatrist. . . . In the process of 'becoming,' an indispensable ingredient will be long and intensive involvement with individual patients" (12, p. 99). For the gifted resident, comfortable with and able to follow the academic role model, intensive clinical involvement with patients is the activity least likely to be rewarded by peers because it is most difficult to evaluate objectively and therefore may be underemphasized in early career decisions. For the average resident who is unable or unwilling to follow the triple-threat model, selection of a subspecialty career tract (administrative psychiatry, research psychiatry, full-time academic psychiatry, forensic psychiatry, or social and community psychiatry) in an attempt to excel in one area could result in "selective inattention" to meaningful personal involvement with patients. All residents approaching career decisions must carefully explore the implications of such subspecialty choices for their further clinical maturation.

UNIVERSITY AFFILIATION

With the majority of residents now being trained in the university system, one early career decision must deal with continuation or discontinuation of the university affiliation. Although few authors have discussed the issues involved in these decisions, Romano (13) and Engel (14), in their writings on the concern that psychiatry is withdrawing from medicine, have clearly stated that at least some work within the medical school setting is crucially important to the psychiatrist's continued evolution as a competent professional. However, discussions of the relative advantages and disadvantages of salaried full-time, geographic full-time, part-time, or donated-time positions are rare. The question of staying at one's training institution versus moving on to other centers and other opportunities is rarely debated. In many major university centers, graduated residents stay on in minor staff positions, causing such saturation of psychiatric talent in certain areas of the country that creativity and personal development are often smothered. Failure to be "accepted" on the staff is often seen as complete rejection of one's worth as a psychiatrist. Opportunities in other geographical areas or in newer, less known, less developed departments of psychiatry are not explored, perhaps again partially due to the prestige and relative safety of working in the parent university, which is reinforced by the presence of the local academic role models.

Many myths need to be carefully explored in considering types of university affiliations. For example, the relative merits of salaried full-time versus geographical full-time positions have been recently examined by Maloney in one of the very few well-designed investigations of this question.

> For nearly half a century, GFT (geographic full-time) faculty members have been considered to be economically motivated, to do little research, to have minimal extra-mural grant support, to be distracted from their teaching obligations by clinical practice, to spend little time with students, to neglect administrative matters, and to lack scholarly distinction. In contrast, SFT (salaried full-time) faculty are viewed as having intellectual rather than economic motivation, to engage actively in research, to have abundant grant support, to spend much time teaching, to be available to students, to carry a heavy administrative burden, and to achieve national and international recognition for scholarly activities. . . . Interestingly, all but one of these shibboleths are false. (15, pp. 5–8)

Maloney noted that all but one of these stereotypes were false (salaried full-time faculty did spend more time in research-related activities). Other myths for consideration might include the following: 1) the prestige of faculty appointment outweighs all other considerations (financial sacrifice, etc.), 2) the acquisition of tenure is a most important consideration in weighing academic affiliation, 3) patients prefer to be cared for by the university physician, 4) competence as a specialist is related to the degree of involvement in the medical center setting, and 5) medical students and house staff learn "most" from academically oriented teachers. These and other diverse issues regarding academic affiliation must be discussed with eclectic residents who are trained within the university setting.

THE ROLE OF PRIVATE PRACTICE

Private practice remains a relevant professional activity worthy of consideration by the newly trained psychiatrist (16). Kubie has observed, "Private practice has many defects, but in spite of them it has been our best teacher for years" (12, p. 99). The role that private practice can play in the continued evolution of clinical maturity should be abundantly clear to even the casual observer interested in psychiatric training. Personal involvement with patients, whether the modality is individual, marital, family, group, or community therapy, is a basic role model requiring careful consideration by every psychiatrist. Few eclectic training programs, however, offer significant opportunities for senior residents to explore with private practitioners of psychiatry the many complex issues involved. In fact, the classic salaried full-time system interdicts private practice or allows only a group or a professional association practice in which definite financial advantages exist for the department or sponsoring organization.

The negative set that exists in many academic psychiatric communities toward private practice is such that not only are discussions of the problems and advantages of private practice completely avoided but clinical teachers who are actively engaged in private practice are frequently devalued and become negative role models for training residents. In a recent survey of practicing psychiatrists in Florida, Warson and Denman (17) found that 28 percent of the psychiatrists surveyed felt that their formal residency programs trained them less than adequately for the problems they encountered in psychiatric practice, and 83 percent felt a lack of preparation for the necessary practical aspects of private practice. Allen, who was successful in organizing private practice seminars for senior residents at the University of Cincinnati, found that a very significant factor was "the residents' need before they severed their ties to their training institution for an opportunity to expose and discuss problems that they might expect to encounter in their role as (practicing) psychiatrists" (18, p. 418). Few eclectic programs offer such discussion groups as a part of formal residency training.

PERSONAL PSYCHOTHERAPY OR TRAINING ANALYSIS

The role confusion typically experienced by first-year residents is reawakened as they struggle with decisions on career directions in the early postresidency years. Dynamic eclecticism, with its systematic rather than theoretical cohesiveness, presents the young psychiatrist with multiple career directions but no unitary ethical, theoretical, or philosophical position. Academic role models are presented for emulation that may not be appropriate to the residents' career goals or professional potential. It is perhaps possible to speculate that senior residents and young psychiatrists will now seek personal psychotherapeutic experiences not primarily for purposes of training but at least in part to assist them with career decisions and with understanding their underlying conscious and unconscious motivations. Further, the eclectic resident has difficulty discussing these decisions with faculty who are often too busy to listen or too "powerful" for residents to approach comfortably. Career preceptors are rare in training programs, and career seminars are infrequent. The senior resident is essentially alone and anxious as he approaches this important crossroad in his young career. Some authors have noted the waning of psychiatric interest in formal psychoanalytic training, but many young psychiatrists are still engaging in their own personal psychotherapeutic experiences (19). Pressure for earlier career decisions, in part related to the present discontinuation of obligatory government service, could strengthen this trend, which is considered a healthy one by many. Thus an important experience could be added to the residency years in a manner that is perhaps more responsive to the individual needs of residents than the earlier imperatives for formal analytic training, which often succeeded in only further compounding the dilemma of the early postresidency years.

CONCLUSIONS

The need of the senior eclectic resident for thoughtful career counseling has increased as the discontinuation of obligatory postresidency government service adds to the dilemma of career decision making. Whatever the resident's ultimate choice of early career directions, departmental chairmen and residency directors must attempt to develop programs to objectively present the vast amount of data that now exists regarding multiple career options. It is important to note that academic role models are not necessarily the only appropriate models for emulation by all residents. Career preceptors should be developed within the university-based training program to help senior residents work through what has been described as the senior resident syndrome. Formal or informal seminars fully sanctioned by the department should become foci for discussion of such career decision issues as the importance of clinical work in the further development of psychiatric judgment, facts about university affiliation, the role of private practice, and the desirability of personal psychotherapy.

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EDITORIAL

The Ideal Physician

IN A RECENT COMMENTARY in the *Journal of the American Medical Association*, Dimond (1) highlighted the desirability as well as the difficulty in selecting scientifically qualified medical students possessing the personal quality of compassion—a generally accepted characteristic of the ideal physician. In another *JAMA* article, Pellegrino (2) proposed that historically and practically, achieving a consistent triad of excellence in skill, knowledge, and humanistic attitudes (the ideal physician?) is perhaps unlikely except for a "very few persons."

The ideal physician has been described as a compassionate medical scientist (1), as a humanist physician (2), and as one who practices "the art and the science" of medicine (3). What is meant by "compassionate," "humanist," or "art" when one is defining the qualities of an ideal physician? If one cannot define these specific qualities, how then can one proceed to select such a person or develop enhancing educational programs for him?

There seems to be little debate about what a scientific physician is: he or she must base his/her professional skills and practice on the foundations of scientific discovery, on information and techniques acquired by employing the scientific method (and tolerated amounts of logical, deductive reasoning). But when you ask six people to define a compassionate or humanist physician, the usual responses consist of a variety of six commonly agreed upon examples; rarely do they provide a useful or clear definition.

Any effort to deflocculate these muddy waters should identify some basic personality characteristics of the ideal physician that can be teased out and perhaps measured, or at least evaluated. One possibility is that compassionate, humanist, or "ideal" physicians are those who are aware of and concerned with the secondary, affective, and peripheral consequences to their patients of their primary cognitive decisions and scientific activities. Similarly, such physicians are aware of and concerned with the potential cognitive impact on the patient of their own affective responses. Underlying this is the indispensable assumption that the physician possesses an adequate base of scientific knowledge and skill. But if he is to function as an ideal physician, these skills must be practiced within a humanistic framework that implies an empathic attitude toward patient concerns, an attitude that permeates the application of those indispensable scientific accouterments. Aware of their own emotions engendered by the patient-physician interaction, such professionals utilize their energies (anger, love, etc.) for their patient's welfare, not their own, or neutralize these responses effectively in the patient's interest. They foresee and sensitively anticipate the patient's anxiety about his ailment and have the ability to share this awareness either directly, by word, or indirectly, by deed, in a way that tends to replace patient fears with legitimate confidence in the physician.

A recent student-teacher clinic provided a simple example for evaluating medical student humanism, or its potential. A child neurologist and I (a child psychiatrist)

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

were teaching four medical students the key diagnostic features of a mongoloid child. As each of the students examined the child and her epicanthal folds, noted the simian lines across her palms, demonstrated the laxness of her joint ligaments and her muscular hypotonia, one of the students spoke up spontaneously: "Shouldn't we have washed our hands before examining the child?" He was concerned about the sudden and massive application of bacteria, etc., by 12 hands holding, flexing, and rubbing over the nearly naked baby. His sensitive concern was for a possible consequence secondary to the primary cognitive examination activity itself. It was a clue, if one accepts my hypothesis, that this student had the potential for becoming a compassionate medical scientist. His comfort with speaking up about the faculty's failure to suggest this precaution also indicated that he believed he was in an environment that could tolerate compassion and even reward it (he was praised for his alert and appropriate sensitivity).

This example is from the same cloth as that of the physician who warms the stethoscope, takes the time to explain in advance unfamiliar sensations to expect during an examination, or tells a patient that crying with relief is a beautiful thing—and then comfortably allows it to happen.

Both in actual teaching-learning situations and in simulated educational clinics such qualities can be observed, encouraged, perhaps taught, and certainly rewarded. Identification of the personality traits I have described could represent one predictive step across the quicksands of identifying compassionate science students for medical school admission.

An educated awareness of and concern for the affective component of the patient's being tempers and guides the empathic yet calculated, the objective, and the cognitive decisions of the ideal physician. Physicians are advisors, not dictators, in the sense that they give advice and not orders to the patient. They give this advice as freely as they give the patient the privilege of accepting or rejecting it without retribution. They possess the ability to share in the patient's helpless or seemingly hopeless plight while remaining effective in their proper attitudinal attire of knowledgeable hope.

The one common personality thread found in the fiber of an ideal physician may be this educated sensitivity, this sympathic resonance with the patient, which does not affect the physician's objective decision making as much as it affects his style and manner of rendering his decisions or recommendations.

If this attribute—awareness and concern with the affective and secondary consequence of cognitive, scientific decisions and activities—reasonably describes one major characteristic of the ideal physician, a better chance exists for identifying such a person when he or she applies to medical school. There is also a better chance for teaching and practicing such concern after the medical school experience.

The goal of becoming an ideal physician may never be completely attained, but it would seem less courageous to forfeit an unrun race than it would be to lose it after a sincere effort. Without clear recognition of the discernible qualities of the ideal physician and a continuous effort to achieve them, tomorrow's physicians may become little more than tradesmen, unwitting traitors to a great profession and a viable tradition.

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Improvement of Parkinsonism in Depressed Patients Treated with ECT

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Two patients with severe Parkinson's disease were treated with electroconvulsive therapy for a supervening depression. Not only did the symptoms of depression clear up after only four treatments, but the parkinsonian signs also showed striking and sustained improvement. This may be related to ECT-induced changes in dopamine and norepinephrine metabolism. Parkinsonism does not appear to be a contraindication to ECT. On the contrary, ECT may be the treatment of choice for certain patients with Parkinson's disease, whether or not it is complicated by intractable depression.

MENTAL DEPRESSION OCCURS commonly in patients with Parkinson's disease. Therapeutic response to tricyclic antidepressant drugs is often disappointing and too slow for emergency use. Many clinicians have been reluctant to use electroconvulsive therapy to treat depression in patients with severe rigidity and bradykinesia. We recently treated two such patients suffering from severe depression and classical Parkinson's disease with ECT. Their depression was alleviated after only four treatments; surprisingly, the objective parkinsonian signs also showed striking and sustained improvement.

CASE REPORTS

Case 1. A 62-year-old lawyer first became ill in December 1961, when he developed an acute paranoid depression precipitated by a stressful situation in his work. He was given six electroconvulsive treatments, recovered temporarily, but later relapsed. In April 1962 he was admitted to a psychiatric hospital where he received perphenazine (Trilafon), benztropine mesylate (Cogentin), and imipramine (Tofranil). His condition remained static, with depression and paranoid delusions predominating. In December 1962 he developed masked facies and decreased arm swing, especially on the right side. Cerebrospinal fluid was normal. The mild parkinsonian signs were attributed to side effects of drugs.

Because his paranoid delusions persisted he was transferred to another hospital and given up to 600 mg of chlorpromazine (Thorazine) daily, 2 mg of benztropine mesylate daily, 10 mg of dextroamphetamine (Dexedrine) each morning, and 5 mg of trifluoperazine (Stelazine) twice daily. He improved rapidly during the next three weeks. The doses of the drugs were gradually reduced, and he was discharged from the hospital on February 5, 1963. He continued to take 2 mg of trifluoperazine twice daily and 200 mg of chlorpromazine at bedtime. These medications were discontinued in March 1963, and he was discharged from treatment without abnormal psychiatric or neurological signs.

For five years he remained well. In January 1968, following a stressful legal case, he again developed delusions of reference, which disappeared when he was given 2 mg of trifluoperazine three times daily for one week, then twice daily for three weeks. However, his parkinsonian symptoms and signs reappeared, and medication was discontinued. Repeated examinations by neurologists over the next several years showed signs of progressive Parkinson's disease, predominantly on the right side. Because of the asymmetry and typical clinical course of the disease, this was considered to be an independent development.

The patient received no phenothiazines for the next four years, but by June 1972 his rigidity and bradykinesia had become much worse despite treatment with trihexyphenidyl (Artane). Within one week he also became depressed, delusional, and pathologically obsessed with trivial episodes from his distant past. Chlorpromazine, in doses of up to 600 mg daily, failed to produce the improvement that had occurred nine years earlier. By June 28 he was so rigid that he could not move, and all medications were discontinued. During the next few months his rigidity and bradykinesia improved slightly, but he was barely able to function. He continued to take anticholinergic agents —benztropine and biperiden (Akineton)—but he was not given L-dopa because of his fragile psychiatric state.

By September 1972 his delusions had returned with such force that he was readmitted to the psychiatric unit of Sibley Memorial Hospital. He was in a state of profound depression and psychomotor retardation. He could not rise from a chair, his face was masklike, and he showed a typical dystonic parkinsonian posture. He had difficulty speaking. He had a shuffling gait without festination. He would recoil when pushed on his sternum but would not fall forward or sideways. There was severe lead-pipe rigidity of his neck and limbs, slight cogwheel rigidity in both arms, and a hint of tremor on the right side. He

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was mentally confused and appeared to have auditory and visual hallucinations. On several occasions he was incontinent of urine.

He was given four ECTs between September 28 and October 5. Each was preceded by intravenously administered sodium methohexital (Brevital) and succinylcholine hydrochloride (Anectine), and they were well tolerated. The treatments were followed by remarkable and rapid improvement not only in his mental condition but also in his physical state. The muscular rigidity and immobility of his face almost disappeared. His speech and gait improved greatly, particularly after the second treatment. His delusions disappeared after the third treatment. He smiled readily and walked about the ward spontaneously. His gait was no longer shuffling, although arm swing was diminished. He lost retropulsion to sternal push. The speed with which he initiated and performed movements was remarkably increased. His superior mental faculties were clearly unimpaired. He was discharged on October 9, 1972.

He has been seen at regular intervals since discharge and has been on a regimen of 2 mg of benztropine mesylate four or five times daily, to which 100 mg of amantadine hydrochloride (Symmetrel) twice daily was later added. Since November 1972 he has resumed his full-time active practice, at which he has remained highly effective. His Parkinson's disease has been stable and there has been no recurrence of psychiatric symptoms.

Case 2. A 70-year-old businessman with a lifelong cyclothymic personality had four severe episodes of manic-depressive illness over a period of 25 years. He had been hospitalized and successfully treated with ECT on several occasions. His last psychiatric illness was a hypomanic episode following a prostatectomy in 1963. This was treated successfully with promazine hydrochloride (Sparine), psychotherapy, and special nursing care. ECT was not used. Promazine therapy was discontinued in January 1964. His recovery was followed by a brief depression, which subsided in April 1964.

He remained well until early 1972, when he developed bradykinesia, cogwheel rigidity, masked facies, shuffling gait, typical parkinsonian tremor, and severe retropulsion. For a while his neurological symptoms were contained by trihexyphenidyl. However, he developed progressive mental depression, primarily because of his inability to engage in many of his previous activities. In February 1973 he became very rigid and immobile. L-dopa (Larodopa) produced remarkable improvement at first, but in spite of increased doses his parkinsonian signs worsened and he became severely depressed. He said, "I see no point in living.... I really want to die." He was unable to sit still and had great difficulty sleeping.

On admission to the psychiatric unit of Sibley Memorial Hospital on April 23, 1973, he was tremulous, anxious, agitated, and despondent. He showed shuffling gait, bradykinesia, and a typical bilateral parkinsonian tremor. He continued to receive L-dopa, the dose of which was gradually increased from 500 mg to 750 mg, four times a day. Meprobamate was given for severe agitation, and he also received 1 mg of benztropine mesylate three times a day.

Between April 24 and April 30 he received a total of four ECTs, each preceded by intravenously administered sodium methohexital and succinylcholine. Immediately after the first ECT the extreme muscular rigidity of his limbs disappeared, only to return an hour later. The next day he showed little or no tremor and he walked without shuffling. He was in better spirits and was able to play bridge for the first time in weeks. After his second treatment he could shave himself and, apart from some slowness in movement, showed no rigidity or any other parkinsonian signs, even though the dose of L-dopa remained unchanged. When he was discharged on May 2, 1973, he was no longer depressed and was walking without difficulty. The improvement in both neurological and psychiatric symptoms has been sustained. The only medication he continues to take is 750 mg of L-dopa four times a day.

DISCUSSION

The coincident improvement of parkinsonian and depressive symptoms in these two patients suggests a common biogenic action of electroconvulsive therapy on both aspects of their illness. The exact mechanism of action of ECT in depressive illness is unknown, but the passage of an electric current through the brain, which produces a convulsive seizure, probably exerts its effects at many anatomical levels and produces many different chemical alterations in the brain, including the concentration and turnover of catecholamines (1–4). The role of depressed levels of brain dopamine in the pathogenesis of Parkinson's disease is now generally accepted. Similarly, the catecholamine theory of endogenous depression has received clinical and experimental support (5, 6). Because ECT improved the parkinsonian signs in these two patients, it is reasonable to ask whether it did so by increasing dopamine synthesis. This would have important implications for the norepinephrine theory of depression. Dopamine is the precursor of norepinephrine, and ECT may produce its antidepressant action by increasing the synthesis of dopamine and norepinephrine.

The therapeutic effectiveness of L-dopa in the treatment of Parkinson's disease is well known (7), but its role in the pathogenesis of affective disorders is less clear. Patients treated with L-dopa have developed a variety of mental changes. These include enhancement of memory, elation, hypersexuality, depression, excitement, hallucinations, delusions, and frank psychosis. The drug may cause deterioration of the mental state of schizophrenic patients (8). Paradoxically, L-dopa has been reported to cause depression (9–11) as well as to alleviate it (12). Tricyclic antidepressant drugs, which probably increase available brain norepinephrine, are effective agents in relieving depression in parkinsonian patients receiving L-dopa. It might be supposed that ECT would act similarly.

Were the extreme rigidity and bradykinesia of our two patients a manifestation of Parkinson's disease or the result of psychomotor retardation? The typical tremor, bradykinesia, severe muscular rigidity, characteristic posture, shuffling gait, retropulsion, and other features of Parkinson's disease clearly confirm that they were in an advanced phase of parkinsonism.

We are well aware of the effects of phenothiazines on the extrapyramidal system and their capacity to cause drug-induced parkinsonism or to aggravate preexisting Parkinson's disease. However, our first patient clearly suffers from classic idiopathic Parkinson's disease, which has been progressive and asymmetric over a number of years during which he did not receive any phenothiazines. In addition, his history revealed that at age 6 he had suffered severely from influenza during the 1918 epidemic.

The question of drug-induced parkinsonism did not arise at all in our second patient since he had not taken any phenothiazines for over 11 years.

Biochemical changes in dopamine turnover or ECT-induced dopamine-receptor sensitivity may explain our patients' improvement. More difficult to explain is the maintenance of this improvement for many months after ECT. This parallels a similar improvement in their depression and denotes the induction of long-acting changes in the underlying mechanisms subserving movement and tone as well as mood.

We hope that this report will alert clinicians who are confronted by patients with Parkinson's disease complicated by depression to the fact that ECT is not contraindicated and in some cases may be the treatment of choice. It remains to be seen whether ECT will be equally effective in helping parkinsonian patients without associated mental depression or those who fail to improve with L-dopa.

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Classification of Suicidal Behaviors: I. Quantifying Intent and Medical Lethality

BY AARON T. BECK, M.D., ROY BECK, AND MARIA KOVACS, PH.D.

Previous studies of attempted suicide have cast doubt on the value of assessing psychological intent. By identifying a moderating variable, namely, the attempter's preconceptions about the lethality of his act, the authors were able to solve the puzzle of the low correlations between intent and lethality. Suicidal intent correlates highly with medical lethality when the attempter has sufficient knowledge to assess properly the probable outcome of his attempt. The authors conclude that suicidal intent and medical lethality are useful dimensions in classifying suicidal behavior.

THE STUDY OF SUICIDAL BEHAVIORS has been chronically handicapped by semantic confusion, amorphous concepts, and contradictory taxonomies.[1] Many writers have lumped completed suicides and nonfatal suicide attempts together as though these constituted a homogeneous group. Nonfatal suicide attempts have been reported simply as unsuccessful suicides. The controversy surrounding the question of suicidal intent has spawned a variety of terms such as "suicidal gesture," "abortive suicide," "simulated suicide," "pseudosuicide," and "sub-intentioned suicide." It is often difficult to understand what a writer means by a "serious suicide attempt" because some authors confound the degree of an individual's intent to kill himself with the medical consequences of his suicidal act (2–5). Other investigators, dismissing the wish to die as the motive for most cases of nonfatal sui-

[1] A complete review of the literature on taxonomies and nomenclature of suicidal behaviors was made by Beck and Greenberg (1).

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cide attempts, have coined the term "parasuicide" to indicate that such cases mimic suicide (6).

In recent years a number of efforts have been made to introduce greater conceptual clarity and order into the study of suicidal behaviors. A major step in this direction was Stengel and Cook's separation of suicidal intent from the physical consequences of the suicidal act (7). More recently, a system of classification was prepared by the Committee on Classification and Nomenclature, Center of Studies of Suicide Prevention, National Institute of Mental Health. This committee classified suicidal behaviors into three major groups: completed suicides, attempted suicides, and suicidal ideation (8).

The problem of denoting the genuineness or seriousness of an individual's attempt or desire to end his life was handled by conceptualizing intent as a dimension. Thus a patient who gave unmistakable evidence of a determination to end his life but who suffered little physical damage as a result of his suicidal attempt would be rated high on the intent scale and low on the medical lethality dimension. This classification scheme was strongly supported by Stengel in his presidential address at the sixth meeting of the International Association for Suicide Prevention (9).

In order to operationalize the concepts embedded in the new system of classification, Beck and coworkers (10, 11) developed, refined, and cross-validated a clinical scale for measuring suicidal intent in nonfatal as well as fatal suicide attempts. These investigators also developed a scale for assessing the degree of medical lethality[2]—that is, the danger to life resulting from a suicide attempt. However, since we found a low correlation between suicidal intent and medical lethality, a finding also reported by others (7, 13), this study was designed to determine whether certain previously unexamined factors might have contributed to the discrepancy between intent and lethality.

We hypothesized that by taking into account the suicide attempter's preconceptions of the lethality of his act, we could demonstrate that suicidal intent is an important determinant of medical lethality. We predicted that the group of patients who had accurately anticipated the dangerousness of their self-destructive actions would show a high positive correlation between intent and lethality, while those who had not would show a low or negative correlation.

METHOD

The subjects were 227 patients admitted following a suicide attempt to the Philadelphia General Hospital or the Hospital of the University of Pennsylvania over a period of two years. Data were obtained through a comprehensive psychiatric interview by an experienced clinician (M.K.), who evaluated the patient on his suicidal intent, the medical lethality of the act, and his conception of medical lethality.

Suicidal intent was measured by the Suicidal Intent Scale (SIS) (10). By taking into account all of the relevant aspects of the attempter's behavior before, during, and after his suicidal act, the SIS provides a comprehensive representation of suicidal intent. The scale is a 15-item schedule consisting of two parts. Part I (items 1–8) covers the objective circumstances of the attempt and includes items on the preparation for and manner of execution of the attempt, the setting, and clues given beforehand by the patient that could facilitate or hamper intervention or discovery (isolation, precautions against discovery, suicide note). Part II (items 9–15) reflects the attempter's report of his conception of the method's lethality, the extent of premeditation, the alleged purpose of the attempt, and his expectations of the possibility of rescue. All items are scored on a 0–2 scale of severity. The total score range is 0–30.

A high degree of interrater reliability and validity in discriminating between attempted and completed suicides has been reported (10, 11) for part I. Other studies (14, 15) have supported the construct validity of the instrument.

Medical lethality was measured on a scale of 0–10. Ratings were based on an examination of the patient's physical condition on admission to the medical, surgical, or psychiatric service; a study of his medical charts; and consultation with the attending physician. The SIS was completed before and independently of the rating of medical lethality. The demographic characteristics of the sample have been described elsewhere (16).

An index of the accuracy of the preconception was obtained by comparing the patient's expectation of lethality just before or during his suicide attempt (item 11, conception of lethality) with the actual lethality. The sample was divided into three groups according to preconception of the lethality of the act: 1) patients who did less to themselves than they believed would be fatal, 2) patients who were uncertain regarding the ultimate lethality of the attempt, and 3) patients who equaled or exceeded what they thought would be lethal.

The expectation-outcome relationship allowed us to classify the patients according to the accuracy of their predictions and to compare these groups on other dimensions. There were 65 attempters in the low-expectation group, 63 in the uncertain group, and 99 in the high expectation group. Using actual lethality as the criterion, the sample was then divided into three groups approximating the frequency distribution of the initial three groups. There were 63 attempters in the low medical lethality group (lethality = 0,1), 70 in the middle (lethality = 2,3), and 94 in the high (lethality = 4 or above).

Because the distribution was skewed toward the lower end of the lethality scale, the high-lethality group includes more scale units than do the other lethality groups. A patient was designated as an accurate predictor when he was placed in the same expectation and actual lethality groups (low, middle, or high). Ninety-two of the attempters fulfilled this criterion of accuracy: 24 were in the

[2] Lethality is used here in the conventional medical sense—the danger to life resulting from injury—in contrast to Shneidman's use of the term (12) to designate an individual's intentionality to self-destruction.

low group on both measures, 21 in the middle on both, and 47 in the high on both. One hundred thirty-five patients who did not meet this criterion were thus classified as inaccurate predictors.

The suicidal intent score was then computed for each expectation-outcome category. In analyses involving the SIS, item 11 (conception of lethality) was subtracted from the total scale score so as not to bias the results.

RESULTS

The correlation between suicidal intent and medical lethality for the entire sample was low (.19 by Pearson product-moment correlation). The accurate predictors, however, showed a high positive correlation between intent and lethality (.73). In other words, high or low intent in this group was reflected in a high or low degree of lethality, respectively. The intent-lethality correlation for the inaccurate predictors, on the other hand, was −.25.

The accurate predictors also showed an ascending order of SIS scores (6.67, 10.10, and 16.30) for each increasing level of lethality. The inaccurate predictors showed decreasing intent (14.18, 12.98, and 9.52) with increasing lethality. One-way analyses of variance of the means of the three groups yielded an F ratio of 58.07 ($p < .01$) for the accurate predictors and a ratio of 8.57 ($p < .01$) for the inaccurate predictors. Clearly, for accurate predictors there was a very strong positive relationship between lethality and intent while for inaccurate predictors there was an inverse relationship.

The overall correlation between the patients' expectations and actual lethality was .20 by Pearson product-moment correlation, a finding that indicates that the patients as a group did not have an accurate conception of the consequences of their suicidal acts. This low correlation also supports the assumption that the patients, in general, did not adapt their response to item 11 to conform to the actual outcome. No significant differences were found between the accurate and inaccurate predictors in regard to their mean SIS scores, mean conception of lethality (item 11) scores, sex, age, race, education level, or previous suicide attempts.

The patient's expectation of the lethality of his suicidal act would be expected to correlate highly with intent irrespective of his accuracy in forecasting the outcome. This hypothesis was confirmed by Pearson product-moment correlations between intent and expectation of .76 and .64 in the accurate and inaccurate groups, respectively, and an overall correlation of .69.

DISCUSSION

These results indicate that when a patient has an accurate conception of the lethality of his suicidal act, the resulting degree of danger to his life is proportional to his suicidal intent. The study thus supports the conceptual usefulness of the dimension of intent as a qualifying term in designating attempted suicides and supports the validity of the Suicidal Intent Scale as a measure of the seriousness of a suicide attempt. At the same time, the study confirms the low validity of medical lethality as a measure of the seriousness of intent, since in the majority of the cases the patient inaccurately conceived the lethality of his act. Clearly, as Stengel and Cook (7) pointed out, suicidal intent and lethality must be rated separately.

The dimensions of intent and accuracy of conception of the lethality of the act have important implications for the assessment and management of suicidal behaviors. A patient with high intent and accurate conception would generally be at highest risk, low intent and accurate conception would be at lowest risk, and high intent and inaccurate conception at intermediate risk.

A recent study by our group (17) indicated that suicidal intent as measured by the SIS is a result of the interplay between the wish to live and the wish to die. Further work is now in progress to develop criteria for diagnosing those who simply seek to imitate suicide ("parasuicide") and to determine the incidence of such cases compared with patients whose act represents a desire to end their lives.

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Hormonal Relationships in Homosexual Men

BY GARFIELD TOURNEY, M.D., ANTHONY J. PETRILLI, M.D., AND LON M. HATFIELD, PH.D., M.D.

The authors note that previous data on the role of biological factors in homosexuality have been suggestive rather than definitive. They investigated hormonal metabolism in heterosexual and homosexual men and found no indication of disturbed functioning in the homosexual subjects. The authors discuss problems with research in this area, suggesting the need for larger samples, attention to the factor of diurnal variations in hormonal secretion, and methodological refinements.

A FEW recent studies have suggested a possible biological disturbance in homosexual subjects. A brief report by Lorraine and associates (1) described low urinary testosterone and epitestosterone levels in two homosexual men and elevated testosterone levels in four homosexual women. Another study reported a lower androsterone/etiocholanolone (A/E) ratio of excretion in homosexual men than in heterosexual men. This finding was interpreted as an indication of a disturbance in the metabolism of testosterone in homosexual men (2). Plasma testosterone levels in homosexual men were recently reported to be significantly below those of control subjects in a study that also found a significant reduction in sperm counts related to the degree of homosexual behavior (3). Evans (4) evaluated the body type of homosexual men and reported that they have narrow shoulders in relationship to pelvic width, reduced muscular strength, and reduced body weight compared with heterosexual men. Products of androgen metabolism (17-ketosteroids) were significantly lower in the homosexual subjects, and Evans believed that he had evidence of a reduced A/E ratio in homosexuals, which supported the findings of Margolese (2).

Subsequent reports have continued to reflect the confusion in this area of investigation. Doerr and associates (5) reported no significant differences between homosexual and heterosexual subjects on plasma testosterone levels and semen analysis, but they found significantly elevated plasma estradiol concentrations in the homosexual group. Elevated levels of plasma testosterone in homosexual subjects have been reported by Brodie and associates (6), which admittedly complicates the interpretation of the studies on the subject. Birk and associates (7) examined baseline serum testosterone levels of homosexual subjects undergoing psychotherapy. This group, although not compared with a control group of heterosexual subjects, showed no relationship between Kinsey (8) homosexuality ratings and serum testosterone levels. The testosterone levels were considered to be within the normal range, but with some suggestion of elevation.

The purpose of our study was to evaluate the hormonal relationship between homosexual and heterosexual men in order to clarify a number of issues that currently remain regarding the possibility of some biological disturbance associated with homosexual behavior.

PHYSIOLOGICAL BASIS

Many studies have been performed demonstrating extensive anatomical linkages that provide points of contact for neural and presumably psychological influences on a great many endocrine systems via the hypothalamus and the anterior pituitary gland (9). In this study, the interstitial cell-stimulating hormone (ICSH) and the follicle-stimulating hormone (FSH) of the anterior pituitary were studied, along with the principal androgens secreted by the testes and the adrenal cortex. In the testes, only the ICSH is involved in stimulating secretion of hormones by the testes. FSH is primarily related to the integrity of the semineferous tubules and the production of spermatozoa. ICSH stimulates the interstitial cells to secrete androgens, principally testosterone, which also exerts an effect on the tubules, so that both components of the testes appear to be stimulated by this gonadotropin.

In this study, free, unbound forms of testosterone, androstenedione, and dehydroepiandrosterone (DHEA) of peripheral plasma were measured. Androsterone, etiocholanolone, and total 17-ketosteroids from 24 urine specimens were also determined. Plasma testosterone is a major indicator of testes endocrine function, while DHEA and possibly androstenedione give indications of overall gonadal and adrenocortical functions (10). DHEA and its 11-hydroxy derivatives are secreted by the adrenals in only small amounts and form the precursors for testosterone levels in women. Testosterone is biologically 25 times more potent than either DHEA or androstenedione in the human. Androsterone and etiocholano-

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lone are two major breakdown products of the plasma androgens that are found in the urine. The 17-ketosteroids represent not only the breakdown products from the androgens but also those derived from cortisol and other adrenal hormones. Such total findings reflect a number of metabolic pathways and give only a gross "wastebasket" indication of testicular and adrenocortical function.

METHOD

Subjects

The subjects were 14 homosexual and 11 heterosexual men whose ages ranged from 18 to 32 years, with means of 27.1 years for the heterosexual and 23.8 years for the homosexual subjects. Most of the subjects were college students, and all had average or above average intelligence. Individual height and weight were within the defined ideal for the subject's age. The mean height was 70.7 inches for the heterosexuals (SD=2.8) and 69.4 inches for the homosexuals (SD=2.2). Mean weight was 170 pounds for the heterosexuals (SD=7.2) and 145 pounds for the homosexuals (SD=5.0). The difference in weight between the two groups was significant at the .01 level, although both means are considered to be within the normal range.

The homosexual subjects actively participated in homosexual behavior as their predominant mode of sexual outlet. Heterosexual subjects had heterosexual relationships and fantasies on a regular basis. All subjects were evaluated in a two-hour psychiatric interview, and no evidence of a significant neurotic, schizoid, or psychotic symptomatology appeared. The homosexual subjects regarded themselves as having made a satisfactory homosexual adjustment and denied personal conflicts over their homosexual orientation. They fell into the Kinsey (8) classification of group V or VI, i.e., predominantly homosexual but incidentally heterosexual, or exclusively homosexual.

Hormonal Determinations

Blood specimens for the plasma determinations were drawn when the subject was in a resting and fasting state shortly after awakening in the morning. The 24-hour urine specimen collections were started when the blood was drawn. All specimens were coded, and the technician had no knowledge of their clinical source.

The plasma concentration of ICSH was determined by a radioimmunoassay employing antibodies to human chorionic gonadotropin (anti-HCG), which selectively cross-reacts with ^{125}I-labeled luteinizing hormone (^{125}I-LH) and unlabeled ICSH. The assay used was a slight modification of the method described by Midgley (11). A standard curve of known concentrations of LH was prepared by this method and the plasma ICSH concentration was determined from that curve. All determinations were performed in duplicate, and the precision was ±10 percent. The serum concentration of FSH was determined using the radioimmunoassay method reported by Midgley (12). Antibodies to FSH were obtained from rabbits, and the ^{125}I-labeled FSH was prepared according to the method described by Van Orden (13). The final precision of this method was ±30 percent. Admittedly, the accuracy for the determination of FSH was poor.

The separation and quantitative determination of plasma testosterone, androstenedione, and DHEA were performed by several recently described methods (14), using ether extraction, chromatographic separation, and liquid scintillation counting. The precisions obtained were ±10 percent for the testosterone and DHEA and ±15 percent for the androstenedione. Details of the methods have been described previously (14).

Urinary 17-ketosteroids were determined by the method of Peterson (15). Urinary androsterone and etiocholanolone were determined by a modification of the method of Thomas and Bulbrook (16), using separation by thin-layer chromatography and radioscanning. These methods have been previously reported to have a precision of ±10 percent for all these substances (14).

RESULTS

The data on the gonadotropic hormones are presented in table 1. No statistical difference was found between the two experimental groups for either ICSH or FSH. There were also no significant differences between testosterone, DHEA, and androstenedione in the two experimental groups (see table 1), although the differences in plasma levels for testosterone approached significance ($.05<p<.10$), with the homosexual subjects having the higher level. The ICSH/testosterone ratio, showing the relationship between the gonadotropin secretion and testosterone production, also showed no significant differences.

Table 2 illustrates the urinary excretion products for 24 hours. The 17-ketosteroids, androsterone, eitocholanolone, and the A/E ratios again revealed no significant differences between the heterosexual and homosexual subjects.

TABLE 1

Plasma Levels of Gonadotropic Hormones and Plasma Androgens in 11 Heterosexual and 14 Homosexual Male Subjects

Substance Measured	Heterosexual Subjects		Homosexual Subjects	
	Mean	SD	Mean	SD
Plasma androgens (μg/100 ml)				
Testosterone	0.65*	0.23	0.92*	0.29
DHEA	0.90	0.69	0.55	0.62
Androstenedione	0.06	0.08	0.10	0.11
ICSH/testosterone	4.56	2.70	4.02	2.50
Gonadotropic hormones (μg/100 ml)				
ICSH	3.46	2.19	3.26	1.31
FSH	11.68	5.64	17.50	10.34

*$.05 < p < .10$.

TABLE 2
Measurement of Urinary Excretion Products for 11 Heterosexual and 14 Homosexual Male Subjects

Product	Heterosexual Subjects		Homosexual Subjects	
	Mean	SD	Mean	SD
17-Ketosteroids (mg/24 hours)	16.19	7.16	17.69	5.14
Androsterone (mg/24 hours)	7.42	4.75	9.11	5.12
Etiocholanolone (mg/24 hours)	5.36	2.70	6.15	2.89
A/E ratio	1.64	1.00	1.56	0.57

DISCUSSION

Our findings do not provide evidence of any disturbance in the gonadotropins, the plasma androgens, or the androgen excretory products in homosexual subjects. None of the hormonal findings for the homosexual subjects in this study was statistically different from those for heterosexual subjects. There was a suggestion of an elevation of plasma testosterone in the homosexuals ($.05<p<.10$); a larger number of comparable subjects should be studied in order to clarify this observation. These results do not support any of the recent reports implying some disturbance in androgen metabolism in homosexual subjects.

We did not find the reduced testosterone or lower A/E ratios in homosexual men that have been reported in other studies. Kolodny and associates (3) used a similar subject population, but there was considerable drug abuse among a number of his subjects, whereas none of our subjects was active in the drug subculture. One should also note that Margolese's (2) subjects had much more age variation than our subjects. The influence on androgen metabolism of the age factor and of drug abuse, particularly the use of marijuana, needs to be clarified.

Our studies have admittedly not been comprehensive in that we have had a limited number of subjects, poor reliability for the measurement of ICSH, and limited success in accurately measuring the levels of estrogens and progesterone in male subjects. Further investigation of these problems is necessary, particularly in view of Doerr and associates' report of elevated estradiol levels in homosexuals (5). The possibility of elevated testosterone levels, which has been suggested by our study and reported by Brodie and associates (6) for a larger sample, should be investigated with more subjects. The only overall significant difference in our study was the lower weight of the homosexual subjects, but this difference was within normal limits.

Researchers also need to be aware of diurnal fluctuations in hormonal levels and the need to control this factor. For example, recent studies have indicated that testosterone secretion rises independently of ICSH during sleep while remaining constant or fluctuating with ICSH activity during the day (17). These investigators believe that testosterone levels may be related to sleep stages. Another study strongly suggests that DHEA secretion is regulated primarily by adrenocorticotropic hormones in a manner synchronous with cortisol (18). Such studies indicate the need to examine these hormonal findings throughout the day and night, regardless of the inherent difficulties of such a task.

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Recertification for Psychiatrists: The Time To Act Is Now

BY S. MOUCHLY SMALL, M.D.

Because of the predictions of partial obsolescence for psychiatry as a profession and because of the increasing pressures of government, third-party payers, and a patient population that will no longer blindly follow physicians, psychiatrists must face the demands for professional accountability. The author suggests that to maintain high-quality care and continuing self-governance, psychiatrists must participate actively in self-assessment and continuing education programs.

MANY OF OUR COLLEAGUES are still fighting a rear-guard action in a battle that should never have been joined. They adamantly refuse to recognize that the public weal requires visible efforts on our part to ensure the highest quality of medical service we are capable of giving.

The medical profession has lost many of its leadership prerogatives, partly through unawareness of and failure to respond to obvious social and political processes. The consumers of medical services no longer blindly follow respected physicians; understandably, they demand to be fully informed. However, the medical profession is in danger of being overmanaged and drowned in a flood of compulsory regulations by government and by well-meaning but too frequently nescient lay groups (1). As the pace quickens, we must demonstrate to all that we are worthy of self-governance.

Educational leaders (2, 3) have reported that as professionals we face partial obsolescence in 5 to 10 years unless we implement our dedication to the principle of lifetime learning and scholarship.

Consumer sophistication about medical problems, diseases, and drugs has increased the pressure for professional accountability. A nationally circulated newspaper asked the question, "Do Doctors Need a Checkup?" (4). Of 350,000 physicians in the United States, about 238,000 are designated as specialists, but only half of these are certified by a specialty board. The newspaper (4) quoted Dr. Robert C. Derbyshire, past president of the Federation of State Medical Boards of the United States and member of the New Mexico Board of Medical Examiners, as saying that at least 5 percent of the physicians in our country are incompetent or barely able to keep up with modern clinical practice by reason of illness, senility, or perhaps lack of motivation. Yet these physicians are rarely weeded out by the profession.

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MEDICINE'S REACTION TO RECERTIFICATION

The APA Board of Trustees has supported the recommendation of its Council on Medical Education and Career Development to require participation in continuing education experiences for maintenance of active membership status.

If Congress passes a national health insurance bill, it will most likely mandate continuing medical education and some form of periodic reevaluation of physicians through relicensure and recertification.

Twenty-one out of 22 specialty boards in the American Board of Medical Specialties (the exception is the board for neurosurgery) went on record in March 1974 as favoring a recertification policy at their conference in Houston. The American Medical Association has given an impetus to voluntary continuing education experiences by means of its Physician Recognition Award. The American Board of Family Practice certifies its specialists for a limited period of time; its first recertification examination is scheduled for 1976.

This flurry of activity and praiseworthy resolutions, however, means little to the medical consumer unless we squarely face up to the central issue of prohibiting the practice of medicine by incompetents.

Psychiatry is particularly vulnerable in this matter. In a tracking study of trends in graduate medical education and specialty certification in the United States, Levit and associates (5) reported that 98 percent of self-designated psychiatrists entered the residency training process but that only 58 percent even registered for the written examination (part I) of the American Board of Psychiatry and Neurology. This compares with 96 percent, 91 percent, and 84 percent for surgery, pediatrics, and internal medicine, respectively. The statistics for ultimate board certification expose similar invidious comparisons: 34 percent of practicing psychiatrists have been certified, compared with 89 percent for surgery, 87 percent for pediatrics, and 61 percent for internal medicine. The proportion of psychiatrists who try for or achieve certification is clearly and disturbingly smaller than that for the other major specialties. (Family practice, approved as a primary specialty board just five years ago, is excluded from these calculations.)

Although certification, as distinguished from licensure, is not a legal requirement to practice a specialty, it does infer a willingness to be evaluated by one's peers on matters of clinical safety and competence. These are the very concerns of medical service consumer groups, government agencies, and third-party payers. The fact that psychiatry is primarily an office-based practice may partly explain the small number of psychiatrists who enter the

certification process. However, neither this reason nor negative attitudes toward being judged will carry much weight with the public. Lack of certification will eventually lead to an indictment of psychiatrists because professionals are expected to govern themselves and should assume responsibility for providing the highest quality of medical services.

Strengthening the requirements for the practice of medicine may not be an unmitigated blessing. In New Mexico, where continuing education became a legal requirement in 1971, a trend has been seen toward physicians' retiring earlier and moving away from the small towns to urban areas, where continuing education courses and "miniresidencies" are more readily available for updating knowledge and skills. Whether the requirement for recertification has improved the quality of care has not yet been determined (4).

SUGGESTIONS FOR PSYCHIATRY

What shall we do as psychiatrists? The lead time for us to set our house in order is rapidly growing shorter. We should take steps before others take this opportunity away from us. APA has taken the initiative in offering two Psychiatric Knowledge and Skills Assessment Programs (PKSAP). It is now preparing its third offering. Since the PKSAP serves as a positive educational stimulus and since no penalty is involved regardless of individual performance, it should be an integral part of continuing education for psychiatrists. It could even be made mandatory for active membership; a given number of credit hours could be assigned for such participation.

Although physicians, who tend to be individualists, may bristle at this suggestion, it builds on the common desire among doctors to serve their patients with a high degree of competence and effectiveness. Assessment programs are most beneficial to all concerned when they are implemented in a fashion that minimizes threats and uncertainties. Rather than stressing their regulatory functions, we should view these evaluations as opportunities for self-improvement and as part of the process of continuing education.

Despite the deficiencies inherent in written excercises and justifiable doubts concerning clinical relevance of parts of previous self-assessment programs, the PKSAP has been used by residents as a preparatory base for American Board of Psychiatry and Neurology (ABPN) examinations. It could also serve as a preparation for certification and recertification programs. Closer coordination and integration of APA's continuing education and self-assessment programs with the ABPN's contemplated recertification examination would be of great value to all concerned.

Perhaps a syllabus fashioned along the lines of content suggested in *Prospects and Proposals: Lifetime Learning for Psychiatrists* (6), which attempted to define the essentials of knowledge under the rubrics of a permanent core and a relatively time-bound core coupled with an extensive bibliography, would encourage self-education. The items in the self-assessment program would be based on the syllabus, as would part I of the ABPN examination. Experience with the PKSAP could be made a prerequisite for registering for recertification examinations in psychiatry, just as the American Board of Internal Medicine now requires participation in its program, the Medical Knowledge Self-Assessment Program (MKSAP), in medicine. The experience and self-confidence gained by many clinical psychiatrists in using the PKSAP may lead to a larger number willing to enter the certification process.

CONCLUSIONS

As specialists, we are charged both individually and collectively with ethical and professional responsibilities. Many of us who are actively engaged in continuing education and evaluation programs have made pleas for suggestions, creative critiques, and technical help from all of our colleagues with knowledge and expertise in this area. The structure of testing must eventually be placed on a solid foundation of clear validation and clinical ability. We need to develop a rational and comprehensive sequence of examinations that make use of a variety of techniques and that are geared to the stages of professional development (7).

The challenges are many in these parlous times as we work to redefine our identity as psychiatrists. To meet these challenges effectively will require the combined constructive efforts and wisdom of all of us who are dedicated to giving the highest quality of medical service.

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The Treatment of Night Terrors Associated with the Posttraumatic Syndrome

BY JOHN R. MARSHALL, M.D.

The author describes three cases in which the frequency and intensity of night terrors associated with the posttraumatic syndrome were greatly lessened by administration of imipramine; in one case, the night terrors disappeared completely. Possible explanations for this effect of imipramine are discussed, including the drug's arousal-preventing action. The author believes that the study of sleep EEGs of patients suffering posttraumatic syndrome will prove fruitful.

THE POSTTRAUMATIC SYNDROME is a complex reaction that usually occurs subsequent to a head injury or other severe threat to the individual's life. The syndrome, which is most commonly encountered by psychiatrists, neurologists, and industrial physicians, may include headaches, dizziness, weakness and fatigue, anxiety, depression and emotional instability, difficulty in concentrating, forgetfulness, and general irritability. Although these symptoms may gradually decrease over several months, they occasionally persist and result in a permanent personality change.

Severe and persistent nightmares are frequently associated with the posttraumatic syndrome (1). In their most developed and severe form, these nightmares, called night terrors, consist of a striking combination of subjective, autonomic, and psychomotor phenomena. Patients who can recall them report brief frightening images or events that appear not as part of an ongoing dream but as isolated terrifying moments. This content is accompanied by extreme physiologic arousal, with profuse sweating, deep breathing, and heart rates up to 160 to 170 per minute. Accompanying psychomotor activity may consist of gasps, moans, screams, somnambulism, and violent attempts to ward off or escape from the feared perception. Night terrors appear to be distinctly different from the more frequent ordinary nightmares that occur during the REM state, which are characterized by less intense anxiety and lower levels of autonomic discharge, motility, and vocalization. Night terrors have been demonstrated to arise from non-REM stages 3 or 4 (2).

In the following three cases imipramine was used to treat this symptom, unintentionally with the first patient and specifically with the others.

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CASE REPORTS

Case 1. Mr. A, a 52-year-old married man, was referred with symptoms of dizziness, weakness, headaches, severe night terrors, excessive binge-type drinking, and generalized somatic complaints. Marital strife and poor work attendance were associated with these symptoms. The symptoms had been present in approximately the same intensity for seven years following cardiac bypass surgery for angina pectoris. Although the surgery eventually proved successful from the cardiac standpoint, there were complications at the time that necessitated treatment in the intensive care unit for approximately six weeks. During that time, the patient was frightened, agitated, and thoroughly convinced he was near death.

A complete neurologic and neuropsychiatric evaluation prior to referral revealed no specific neurologic signs or other evidence of organic brain damage and no history of overt psychiatric illness. The patient had received symptomatic treatment for his anxiety from several physicians during the seven preceding years. A variety of psychotropic drugs had been used, including diazepam, chlordiazepoxide, and meprobamate. He had also been given chloral hydrate and barbiturates for sleep. None of these drugs had more than a minimal effect on any of his symptoms.

The patient described his night terrors as occurring two to three times a night, every night. He denied having nightmares of this type prior to surgery. He could not always recall the varying content of the nightmares, which included frightening dreams of the intensive care unit and, more frequently, of catastrophes. Examples of the dream content included finding himself mutilating a member of his family and terrible accidents or fires in which he or someone close to him was mangled or badly hurt. During these episodes, the patient became quite agitated; he often screamed, thrashed about, or leaped out of bed to cower in the corner. If he awoke, he found himself very anxious, frightened, and drenched in perspiration with his heart beating rapidly. This patient also described what he called "daymares," brief flashes of terrifying events that he estimated lasted for one to two seconds. He reacted to these "daymares" with fear, palpitations, sweating, and near panic. When they passed, he described feeling slightly foolish and embarrassed and hoping that no one had seen him.

The patient was begun on 100 mg of imipramine at bedtime because it was felt that there was a considerable depressive component to this posttraumatic syndrome. One week later, he spontaneously noted that although he did not feel appreciably different the night terrors had ceased on the first night of medication and he was sleeping through the night. The patient's wife corroborated his reports, stating that he had begun to sleep peacefully without screaming or thrashing about. The nightly dose of imipramine was increased to 300 mg over the next several weeks. There was no objective change in the patient's overall appearance, but he reported that he felt better, attributing this to his improved sleep. His wife also felt that while he did

not show any significant improvement in his functioning, he was less irritable. The daymares also ceased. After several months on nightly doses of 150 mg of imipramine, the patient discontinued his medication for approximately six days because he had run out of money. He immediately noted a recurrence of the night terrors, although they occurred less often. When he resumed his medication, they ceased.

Case 2. Mr. B, a 25-year-old married man, was referred for psychiatric treatment 18 months after a construction accident. The patient had been walking on the top of a building and struck his head on a high-power electrical line. He was thrown from the building and suffered a fracture of his cervical vertebrae, lacerations, and severe burns to the scalp. He remained unconscious for approximately two hours and was in traction for six weeks, during which time several plastic surgery procedures were performed on his head.

During the year following discharge from the hospital the patient experienced headaches, dizziness, weakness in the legs, memory loss, and phobic-type feelings regarding automobiles, high places, the sight of blood, or discussion of illness or accidents. He also described night terrors that occurred one to two times a night, five to six nights a week. These dreams, which usually involved his accident or the related hospital stay and treatment, caused him considerable anxiety. He awoke perspiring heavily, with palpitations and excessive psychomotor activity, and frequently cried out during the night. (This was confirmed by his spouse.) The patient had been treated during the preceding year with up to 30 mg of diazepam a day by his local physician, with no notable changes in his symptoms. There was no previous psychiatric history. Neurologic and physical examinations were essentially negative except for the obvious effects of trauma to his head and neck.

Because of my experience with Mr. A, I prescribed 100 mg of imipramine at bedtime and gradually increased the dose to a level of 250 mg. The patient spontaneously described relief from his night terrors, citing a decrease in frequency to one or two a week. He also noted that the character of the dreams changed remarkably. Although he described the content as similar, he noted that he did not feel as concerned and did not awake in a panic with palpitations and profuse sweating. He summarized this by saying, "They seem to be the same dreams, but I don't get as upset about them." There were a few other objective effects attributable to the medication. The patient also described slight improvement in his sense of well-being and wished to continue the medication because of the substantial relief from the night terrors.

Case 3. Mr. C, a 29-year-old man, was referred for psychiatric treatment by his employer's insurance company. He had been injured in an industrial accident one year previously. A heavy piece of metal flew from the machine he was working on and struck him on the head. He was unconscious for several minutes and was hospitalized for observation for two days. In the several weeks that followed, the patient became increasingly anxious and complained of severe headaches, difficulty in concentrating, and recurring night terrors. These symptoms had reached a stable level after several months and continued for the rest of the year.

The frequency of his night terrors ranged from one to two times a night to three times a week. They involved excessive autonomic, affective, and psychomotor arousal, as was described in the two previous cases. He also experienced many dreams that seemed clearly different and did not cause severe anxiety. There was no history of psychiatric illness, and neurologic examinations were negative. Prior to referral, the patient had been treated for his anxiety with up to 40 mg of chlordiazepoxide a day and had used several unknown sleeping medications, all of which were minimally successful in reducing his symptoms. The patient's situation was complicated by continued litigation and his propensity to focus on whether he would receive appropriate and sufficient compensation for his injuries.

The patient was placed on a regimen of 75 mg of imipramine at bedtime and subsequently reported that his night terrors had become quite infrequent, occurring at the rate of one or two a month. The imipramine dose was then increased to 250 mg. After one month without further noticeable improvement, the dose was reduced to 50 mg, which continued to suppress the night terrors.

Several months later, following the unsatisfactory completion of litigation, Mr. C moved from the area and was lost to follow-up.

DISCUSSION

There are several reports in the literature of the treatment of night terrors. Imipramine was reported as effective in the treatment of night terrors in three children with night terrors and somnambulism (3). Glick and associates reported that diazepam successfully suppressed night terrors in children (4). It is not clear whether night terrors in children are the same phenomenon they are in adults, although they appear quite similar clinically. Fischer and associates (5) administered diazepam to six adult subjects and achieved reduction of night terrors from a mean of 1.9 to .48 a night and an overall reduction of 80.5 percent in the instances in which the frequency was reduced. Imipramine was given to one of the subjects for five weeks without success, and it was postulated that adults may react differently to imipramine than children do.

The mechanism of imipramine's action in the elimination of night terrors is unknown. Night terrors do not appear to be a depressive symptom that is alleviated with treatment of that basic condition. Although all of the patients I have described reported increased feelings of well-being and less irritability and fatigue during the daytime (as did Fischer and associates' subjects and as do patients treated with tricyclic antidepressants), it appears that this effect is more related to a restful night's sleep than to direct relief from depression. The symptoms of dysphoric mood, lack of motivation, and interference with sexual functioning remain, as do other symptoms consistent with a diagnosis of depression. Moreover, imipramine's effect on night terrors was seen immediately, and lower doses of imipramine than are needed for the treatment of depression were effective in the treatment of night terrors.

It is unlikely that the effect of imipramine on night terrors in these patients is a placebo effect. The patients were unaware of the effect that was sought by the physician, and two patients had been on several other psychotropic drugs (including diazepam) without similar effects on sleep. Fischer and associates (5), noting that the intensity of night terrors is correlated with the amount of stage 4 sleep preceding arousal, suggested that the suc-

cess of diazepam is related to its effect of suppressing stage 4. They described an unusual effect in one subject in whom there appeared to be a displacement of arousal from stage 4 to stage 2 to REM sleep, and, finally, to the waking state in the form of "daymares." This displacement was accompanied by a reduction in the intensity of arousal (or elimination of the terror). Mr. B in case 2 appeared to experience such a phenomenon in describing lessened intensity of feeling associated with his nightmares following imipramine administration. This would support Fischer and associates' explanation of the mechanism, although Mr. A also described elimination of his "daymares." However, imipramine does not reduce the amount of stage 4 sleep, and Zung (6) has shown that drugs of the tricyclic group actually increase the amount of stage 4 sleep. His work may provide a more plausible explanation of imipramine's action on night terrors. Zung noted that the tricyclics, in addition to increasing the amount of deep stage 4 sleep, lengthened the sleep cycle and reduced the awakenings by causing the individual to be more resistant to outside disturbance. Thus, if night terrors are an arousal phenomenon, as suggested by Broughton (7), they would seem to be reduced by imipramine's arousal-preventing action.

Whether to treat a specific symptom that is only part of a larger phenomenon is a clinical decision. Some clinicians may argue that substitution of another, perhaps more severe, symptom is likely to occur if the night terrors are removed. In general, recent behavioral studies have cast doubt on this old clinical maxim, and the two previous specific studies on night terrors do not report this phenomenon (3, 5). Others may argue that the night terrors represent an attempt by the ego to cope with this traumatic event and/or that they serve as a continuing type of autodesensitization and should not be suppressed. If this is true, the mechanism is not very successful, as the durations of symptoms following the traumatic events in the three cases I reported were seven years, one and a half years, and one year, respectively. The frequency of the night terrors appeared to stabilize rather than to decrease steadily in each case. The patients themselves had few doubts about the value of treating this symptom: two of them stated that control of their nightmares was clearly valuable, and they continued on the medication. A third agreed with this view but was lost to follow-up. Whether indefinite administration of imipramine or a similar medication is required for continued suppression of these symptoms is not clear. In the treatment of depression, imipramine has proved to be a drug that can be given on a long-term basis without a high incidence of side effects or severe adverse reactions.

In my experience, the posttraumatic syndrome is the most common clinical situation with which night terrors in adults are associated. Their association with this syndrome may arise from specific causal or generally associated psychological and/or metabolic factors. It has been suggested that situations which produce anxiety and tension have an effect on the entire hormonal system that leads to an unusual arousal of the reticular system and thereby heightens arousal and sleep disturbance (8). The study of sleep EEGs in patients with a posttraumatic syndrome may prove especially fruitful.

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IN MEMORIAM

Erich Lindemann 1900–1974

ERICH LINDEMANN, who died on November 16, 1974, in Palo Alto, Calif., was one of the most influential psychiatric pioneers of our time—a person who did more than almost anybody else to lay the theoretical and practical foundations of scientific community mental health.

Erich Lindemann was born in Witten, Germany, on May 2, 1900. He studied psychology, medicine, and neurology at the universities of Marburg, Giessen, and Heidelberg before emigrating to the United States in 1927. He worked for eight years at the University of Iowa in the departments of psychology and psychiatry, both as a laboratory researcher and as a clinician. During that period he became interested in abreactive techniques and pioneered the use of sodium amytal as a psychotherapeutic aid.

In 1935 Dr. Lindemann moved to Harvard, where he remained until his retirement in 1965. There he joined a group of psychiatrists at the Massachusetts General Hospital who, under the influence of Dr. Stanley Cobb, trained at the Boston Psychoanalytic Institute. He later became interested in social science and was one of the first psychiatrists in this country to build working relationships with sociologists, anthropologists, and social psychologists. He also worked with Walter J. Cannon at Harvard Medical School on the physiological aspects of homeostasis. He continued his research on the effects of drugs on the neuroses and then became interested in the psychiatric sequelae of hysterectomy and eye operations.

Dr. Lindemann capitalized on all this experience in 1943 when he studied the effects on patients and their families of the Coconut Grove fire in Boston. In 1944 he published what turned out to be the most important paper of his career, "Symptomatology and Management of Acute Grief" (1). In that paper he developed the groundwork of crisis theory and preventive intervention. During the following years he implemented his ideas concerning the primary prevention of mental disorders by establishing a mental health training program at the Harvard School of Public Health that included a multidisciplinary research and practice community laboratory, the Wellesley Human Relations Service.

The Wellesley project, established in 1948, became a prototype for the comprehensive community mental health centers of the 1960s; it developed many of the basic concepts and techniques for the collaboration of mental health specialists with such community caregivers as clergymen and teachers in mental health consultation and education, community organization, and mental health epidemiology that are now standard in this field.

In 1954 Erich Lindemann succeeded his former chief, Dr. Stanley Cobb, as Professor of Psychiatry of Harvard Medical School at the Massachusetts General Hospital. During the following years he tried to introduce preventive mental health ideas into the community life of this medical school teaching hospital. Outside the hospital he extended his researches to the field of city planning by studying the psychosocial consequences for the surrounding population of an urban renewal project. His findings concerning the harmful effects of forced relocation that ignored the consequences of widespread disruption of social ties were a major influence in persuading urban planners to pay attention to the human dimensions of their work.

Erich Lindemann was a superb diagnostician and psychotherapist. He was also a great clinical teacher, and thousands of his students remember vividly his demonstrations of diagnostic interviewing. He had the capacity to draw a sort of magic circle around himself and a patient so that even in front of a large audience an anxious patient quickly began to feel and behave as though he were alone in a room with his therapist.

Dr. Lindemann was also a charismatic lecturer. He rarely used notes, yet was able to cover a complicated topic completely and concisely. His forte was interweaving clinical, physiological, social science, and epidemiological material at a high level of abstraction, and yet in language understandable to his audience, who were held spellbound by his charm, his warmth, his sincerity, his command of a multitude of interlocking factors, and his intellectual clarity.

He spent the last nine years of his life as Visiting Professor of Psychiatry at Stanford University. During that time he suffered from an extremely painful and debilitating illness. In spite of his sufferings, Erich Lindemann continued his studies and teaching and enriched the lives and careers of hundreds of medical students and young psychiatrists. He was a living model of the spiritual strength and the courage to confront and master stress that he advocated in his theories.

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GERALD CAPLAN, M.D.

LETTERS TO THE EDITOR

The Capgras Syndrome in a Male

SIR: Pursuant to the article "The Capgras Syndrome and Its Psychopathology" (August 1974 issue) by B. Frank Vogel, M.D., we would like to report another instance of this syndrome that is of interest because of its occurrence in a male and because of the extent of the delusional system.

The case is that of a 20-year-old man, diagnosed as having paranoid schizophrenia, who believes that his mother and 11 siblings are impostors, their bodies having become inhabited by other people (his father is dead). His real family, he says, have moved on to inhabit other bodies. He also feels that he himself could at times be inhabited by other people, including members of his own family. When asked to describe what led him to these beliefs, he mentions no changes in his family's appearance, but says that their attitudes and behavior have changed. For example, he says that his "alias" mother is too efficient to be his real or "alter" mother. His family's wish to send him to the hospital further indicated to him that they could not be his real family. Consequently, the processes described by Dr. Vogel of splitting the love objects into "good" and "bad" individuals, with subsequent concretization and projection, appear to have developed.

Ms. Dorothy Gavin, a senior member of the nursing staff at McMaster University Medical Center, brought to our attention two additional cases of the Capgras syndrome. Both were women, and both had been diagnosed as having paranoid schizophrenia. In one case, the delusions related to the patient's parents and children; in the other, they related only to the patient's children.

We agree with Dr. Vogel that this syndrome may indeed be more common than was formerly believed, although its occurrence in males remains uncommon for some reason.

ALAN B. EPPEL, M.B.
JACQUELINE MCCORMICK, M.A.
Hamilton, Ont., Canada

A Plea for Cooperative Efforts

SIR: The opinion and comment section in the November 1974 issue has led me to make several observations on the controversy over orthomolecular psychiatry as both theory and practice.

1. Both sides are so involved in attacks and defenses and polemics that they do not see that both arguments may be correct.
2. Each side is passing the burden of proof to the other rather than attempting cooperative work.
3. No one really knows what "schizophrenia" is. Therefore, are Drs. Pauling, Klein, Lipton, and Wyatt speaking the same language? There can be no dialogue unless terms are similarly defined and clearly understood by all.
4. Dr. Pauling is an extremely gifted and discerning scientist who has the uncanny ability to propose major theories on the basis of relatively minimal evidence and then, over the years, to prove or see others prove these theories.

I prefer to view psychiatric dysfunction (signs and symptoms) as the endpoint of a long chain of events, which I will express in the form of a chemical equation:

> Genetic endowment + early life experience + sociocultural milieu + present life stress (biological, psychological, or social) + physiological dysfunction (biochemical, neurophysiological, or neuroanatomical) → signs and symptoms.

The weight of each factor varies in any individual. Thus, theoretically one could become what we term "schizophrenic" largely on the basis of present life stresses. Similarly, in some cases of schizophrenia the major factors could be a genetic deficiency that leads to enzymatic deficiencies, or the insufficient presence of a vitamin apoenzyme, or an acquired subclinical avitaminosis, etc. This may be a necessary condition in only a few of the schizophrenias.

The appropriate therapy, of course, depends on what is most important in the long chain of events (e.g., if early life experiences are considered most important, psychoanalysis would be the appropriate therapy). Thus, megavitamins may be appropriate therapy for those schizophrenics in whom either relative or absolute vitamin deficiency is present.

Obviously, much more work is necessary. As a first step, I would propose that the scientific adversaries put down their boxing gloves, pick up their pens, and work out cooperative, well-designed, unbiased studies.

KENNETH SOLOMON, M.D.
Albany, N.Y.

Defining the AMA Discharge

SIR: The idea that leaving the hospital against medical advice (AMA) may actually be therapeutically beneficial is an important one, and Nancy Scheer and Gail Barton, M.D., M.P.H., are to be congratulated for their article "A Comparison of Patients Discharged Against Medical Advice with a Matched Control Group" (November 1974 issue).

Recently, the Task Force To Study AMAs of the Utilization Review Committee of the Connecticut Mental Health Center learned that most clinicians are still using this designation in highly individualized ways. Documenting a discharge as AMA purportedly guards against the possibility of later lawsuits, but there have been no clear statutes or laws (at least in Connecticut) that explicitly grant this protection.

A patient thinking of terminating treatment may be coerced to remain by the clinician who warns of the dire consequences of termination or who threatens to wash his hands of the case entirely. The patient's decision to terminate in this case involves defying his clinician's judgment, a situation that many patients would prefer to avoid. Worse still, some treatment programs, particularly those involved in drug and alcohol treatment, tell patients that by leaving AMA they disqualify themselves from return for treatment for a prescribed length of time. Still other

programs present the patient with only two choices—continued hospitalization or commitment—before discharge will be considered. Under these circumstances, it is debatable how voluntary the patient's hospitalization really is (1).

The recommendations considered by our task force on AMAs include the following:

1. Using the AMA category only when the patient is not committable, i.e., dangerous to himself or to others.
2. Not using the AMA designation for patients who drop out and leave without telling the staff and who cannot be traced or returned to the facility after repeated attempts.
3. Using the term only when the patient and/or the family have been informed of the pros and cons of the situation (i.e., not making the assumption that they know the possible complications or consequences).
4. Using this term only when, in addition to considerations 1–3, a physician signs or countersigns the order. One hopes that this would prevent a nonphysician clinician from being charged with practicing medicine without a license (i.e., giving medical advice and signing discharge orders).

In this day of rising consumer consciousness and legal sensitivity, the entire question of AMA discharges must be reviewed. The use of the AMA discharge may be a not-so-subtle club, especially when it is coupled with barring the patient's reentry into the treatment process.

The American Psychiatric Association can exercise its leadership in this area by defining the boundaries of the AMA designation before nonclinicians do this for us. We also need a term or terms to deal with the outpatient who wishes to terminate, the situation in which nonphysician clinicians are the primary if not sole therapists, therapeutic communities where discharge decisions are made collectively, etc.

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ANTONIO J. DY, M.D.
New Haven, Conn.

An Unnecessary Bureaucracy?

SIR: The impressive special section "PSRO and Other Peer Review Mechanisms" (December 1974 issue) gives one pause. Twenty highly trained specialists devoted the time and thought necessary to prepare this material. One wonders how many patients could have been treated or administratively helped by these specialists in the time they spent working on this material.

The increasing invasion of bureaucracy into medical practice may eventually destroy the physician-patient relationship and, with it, the art of medicine.

HERBERT I. HARRIS, M.D.
Cambridge, Mass.

A Question of Anatomy

SIR: One of the disturbing features of "Brain Activity During Emotional States" by Robert G. Heath, M.D., and associates (August 1974 issue) is its tenuous anatomical rationale.

For example, the "previously defined" septal region the authors refer to occupies 2 pages in the 619-page book they cite as a reference (1). In that book, the criterion for grouping ("rigidly demarcating") such diverse structures as the septal nuclei, rostrum of the corpus callosum, pyriform cortex, and "various olfactory pathways" under the rubric "septal region" is that they have "particular functional qualities." Since the septal region refers to nervous tissue—not function—anatomical criteria are necessary in defining the term. In fact, the septal region is difficult to define in man because it is so unlike that of animals. In animals, the restricted term "septal nucleus" denotes a large midline structure with readily identifiable subdivisions (2) and, with the exception of the septal nuclei, does not include the structures I have listed that are part of Dr. Heath and associates' definition (in a later article [3], Dr. Heath's definition changed to include the nucleus accumbens, rostral sites of the gyrus rectus, and the ventral medial aspect of the head of the caudate, which are also not part of the septum).

Such an obvious and well-defined structure is lacking in man. In its place, the broader term "septal region" is used to denote the septum pellucidum, which is a thin sheet of tissue separating the lateral ventricles and which may or may not contain nerve cells and, more ventrally, the very small and poorly defined parolfactory (or septal) nucleus and the diagonal band (4). The heterogeneous structures Dr. Heath and associates include in their definitions preclude the possibility of an anatomical criterion for rigidly demarcating this area.

What are the fiber connections between the septal region and other parts of the brain? Figure 1 in Dr. Heath and associates' article diagrams them on a human brain. I know of no studies demonstrating such anatomical connections in man. Possibly, the arrows on this diagram represent an extrapolation of animal experiments to the human case. However, there is no published anatomical evidence of connection between the septal region and ventral lateral thalamus, between the fastigial nucleus of the cerebellum and the hippocampus, or between the interpeduncular nucleus and the septal region by way of the medial forebrain bundle. The only evidence of a fastigio-septal connection is in a publication that Dr. Heath coauthored (5). However, the photographs in that article do not convince me that the authors were capable of distinguishing experimental (degenerating) axons from normal axons not sufficiently suppressed by their staining technique. Finally, figure 1 in their article in the *Journal* shows the amygdala existing in isolation. This structure is connected to other parts of the brain, but not to the sensory thalamus and septal region as Dr. Heath and associates imply.

I feel that "Brain Activity During Emotional States" is an irresponsible article from an anatomical point of view. It is sadly apparent that Dr. Heath and associates were not concerned whether one of their central arguments incorporated an accurate presentation of the neuroanatomy involved.

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BLAIR H. TURNER, PH.D.
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Dr. Heath Replies

SIR: Dr. Turner makes some provocative points. We originated the term "septal region," and the definition, first published in 1954 in *Studies in Schizophrenia* (1), was formulated on the basis of its function. None of the data from our continuing studies with human and animal subjects over the past 20 years has indicated that the original definition was inaccurate. In 1954, the boundaries of this large and heterogeneous brain region were precisely defined. Its caudal aspect is the anterior commissure, its rostral aspect is the tip of the anterior horn of the lateral ventricles, its lateral border includes some of the ventro-medial aspect of what is conventionally considered to be part of the caudate nucleus, its medial border is the midline, its dorsal extent is the septum pellucidum, and its ventral aspect is the orbital cortex.

I think Dr. Turner is mistaken in applying the term "septal region" to the septum pellucidum. To the best of my knowledge, "septal region" has never been used synonomously with "septum pellucidum" in primates. As one moves up the phylogenetic scale, the gray matter between the anterior horns of the lateral ventricle in lower species moves forward and downward. Some but not all of the specific nuclei of the septal region were cited in my original definition. Early studies suggested that this heterogeneous region functioned as a unit, and subsequent studies have supported this contention.

Dr. Turner criticizes our schematic diagram of brain pathways—pathways that obviously have not been and could not be experimentally mapped in man. Experimental techniques for inducing a lesion and subsequently studying axonal degeneration cannot be applied to patients' brains, nor can we use evoked potential techniques that require histologic verification of electrode placements. It is only by extrapolation from animal experiments that brain pathways have been postulated in man.

Dr. Turner is mistaken in several of his points about anatomic pathways. Connections from the septal region to the ventral lateral thalamus have been demonstrated in our laboratories by degeneration studies and by evoked potential techniques. (These studies were referenced in our article.) In addition, we have published a paper demonstrating connections from the fastigial nucleus to the hippocampus (2). These findings have been demonstrated to some well-known anatomists, including Dr. Fred Mettler of Columbia University.

Other pathways Dr. Turner contests were demonstrated in earlier papers by Fink-Heimer degeneration studies and by evoked potential techniques. Subsequently, there have been reports of the anatomic connection between the fastigial nucleus and parts of the limbic system, some of which were prompted by our original studies. (Abstracts of these reports appear in the program of the October 20–24, 1974, meeting of the Society for Neuroscience, which is located at 9650 Rockville Pike, Bethesda, Md. 20014.)

The fact that Dr. Turner is unaware of these pathways does not mean that they do not exist. Had they been known and described in textbooks previously, it would have been purposeless for us to demonstrate them and report them in the literature. The connection between the interpeduncular nucleus and the septal region by way of the medial forebrain bundle has been cited in the literature and is generally accepted. Almost all of the studies on self-stimulation allude to this pathway, since it is important in the reward (self-stimulation) mechanism of animals.

We too were less than satisfied with our early photographs, and we have been working continuously to improve them. Dr. Turner is no doubt aware of the difficulties in the Fink-Heimer technique, as well as its superiority for demonstrating axonal degeneration and degenerating terminals. Staining of normal axons is often very similar to that of degenerating axons. With considerable work and experimentation, we are now able to more clearly distinguish between normal and degenerating axons.

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ROBERT G. HEATH, M.D., D.M.SCI.
New Orleans, La.

Surgery for Tardive Dyskinesia?

SIR: Recently, a patient of mine underwent a right colectomy. Subsequently her tardive dyskinesia of several years' duration disappeared. Her surgeon, Kenneth L. Wiebe, M.D. (650 Hobson Way, Oxnard, Calif. 93030), told me that the only nerves transsected in the surgery were the autonomic nerves leading to the right colon. Preanesthesia included atropine and pentobarbital. Dr. Wiebe told me that he would be glad to correspond with interested individuals.

JOHN M. ACKERMAN, M.D.
Santa Barbara, Calif.

What Should Reassessments Test?

SIR: In view of the general pressure toward some kind of periodic reassessment, it seems to me that we should take a hard look at the results and conclusions reported by Hugh T. Carmichael, M.D., and associates in their article "Results of the 1972 APA Self-Assessment Program" (June 1974 issue).

It appears that the developers of the test assumed that there is a great deal of knowledge gained during residency that is gradually lost over the years after completion of training. The authors talk of a gradual falloff in psychiatric knowledge in their attempts to demonstrate "blind spots" in the knowledge of practicing psychiatrists.

I thought we all agreed that retention of factual knowledge which is not used in daily life or incorporated into the unconscious falls rather rapidly over a period of time. It would follow that the conclusions drawn by the authors would be valid only if we could show that psychiatrists as a group practice in the same way that residents do at the completion of training. Only under those circumstances would something analogous to the American Board of Psychiatry and Neurology exam have very much meaning.

However, if it is the case that psychiatrists quite generally get involved in some specific aspect of the specialty, e.g., psychoanalysis, forensic psychiatry, child psychiatry, or community mental health, then we might expect a certain attrition of factual knowledge compared with the end of residency training. This would, however, be accompanied by a corresponding increase of knowledge in the particular area of expertise. Thus, we could assume that psychiatrists learn more and more about less and less.

I am not sure that this kind of reassessment is necessary at all, but if it is, I think it should consider what people have learned—not just what they have forgotten.

JAMES R. SILBER, M.D.
Los Angeles, Calif.

Dr. S. Mouchly Small Comments

SIR: Dr. Silber's suggestion that many practicing psychiatrists tend to subspecialize is true—involvement in the areas he cites can readily be documented for a significant number of psychiatrists. This would partially explain the gradual falloff in general factual psychiatric knowledge and the development of the "blind spots" observed in the self-assessment program. This decrement was much more apparent in the multiple-choice questions, which covered a broad field of both theoretical and practical clinical items, than in the patient-management section of the assessment program, which related more closely to clinical practice.

Recognition of subspecialization in internal medicine has led to assessment programs in which participants receive a syllabus and recent bibliography of important developments listed under the rubrics of the various subspecialties. The participants have the choice of selecting questions in their particular area of interest. I believe that such an opportunity in the psychiatric self-assessment program is what Dr. Silber has in mind. This option has been discussed by the APA Office of Continuing Education but has not been implemented.

The intent of the Psychiatric Knowledge and Skills Self-Assessment Program is in part to acquaint those who participate with the broad range of problems in diagnosis, modalities of management and treatment, and with related data in behavioral sciences, genetics, epidemiology, and other relevant areas. It is fully recognized that those who confine their practice to psychoanalysis would not necessarily be as knowledgeable about psychopharmacology or forensic psychiatry as would those who use such data in their daily practice. However, when Dr. Silber suggests that this kind of reassessment may not be necessary at all, he overlooks the considerable pressures building up both within and outside the profession for recertification procedures. Self-assessment programs may be looked upon as a helpful preparation for the time when such reexaminations may be mandated.

S. MOUCHLY SMALL, M.D.
Buffalo, N.Y.

We Are Our Brother's Keeper

SIR: I would like to compliment Milton Greenblatt, M.D., on his excellent article entitled "Psychopolitics" (November 1974 issue). He has very ably and perceptively analyzed the state of affairs confronting us in our dealings with politicians.

I have developed an egocentric classification of the human race that has only two categories—enlightened self-interest and unenlightened self-interest. It is to be hoped that psychiatrists are people of enlightened self-interest. It seems to me that our efforts should be directed toward promoting this viewpoint in our fellowman.

I agree with Dr. Greenblatt that if you are living in a jungle, it is nice to be able to identify and evade the spiders, snakes, and boa constrictors. However, I would ask the rhetorical question: Does man have to go on living in jungles, or progressively reverting to them?

In our increasingly pragmatic and hedonistic society, it is becoming more and more difficult to tell the good guys from the bad guys. This is confusing to our young people and has led to increasing cynicism in our society. In our pursuit of happiness, there seems to be a loss of awareness of personal responsibility for our decisions. If we lose sight of the fact that we are our brother's keeper, morality will disappear as an effective community force.

G.D. CARSON, M.D.
Edmonton, Alta., Canada

Journal Review Procedures Criticized

SIR: I wish to endorse the suggestion of Clara G. Livsey, M.D., in her letter to the editor (November 1974 issue) that the names of the reviewers of articles submitted to the *Journal* be disclosed. It is only fair that these reviewers assume responsibility for their opinions. When a reviewer does not wish to assume this responsibility, surely there must be another competent reviewer to take his/her place.

Submitting a paper that has been rejected to another journal often requires much unnecessary reworking; worse, it entails the possibility that the paper will be seen by the same reviewer who rejected it initially. I have seen the same name on the editorial boards of four different journals covering essentially the same field.

BERNARD ZUGER, M.D.
New York, N.Y.

Editor's Note: The reviewer does not turn the paper down—frequently there are three or four reviewers, and they only advise the Editor. The Editor is the culprit, and his name is on the masthead. Blame him.

Reasoned Reevaluation of Community Psychiatry

SIR: I feel that negative statements about community psychiatry in recent issues of the *Journal* (1, 2) call for comment, not only because of the stature of their authors, but because they reflect a feeling that seems to be increasing among psychiatrists—that community psychiatry has somehow failed and, in so doing, has led us all into difficulty.

Having spent a great deal of my career in community psychiatry, I do not pretend to be unbiased. However, I have never supported much of the grandiose nonsense that has been claimed in recent years in the name of psychiatry in general and community psychiatry in particular. I pointed out in 1970, for example, that many community programs then being touted as successes "will eventually be recognized as misguided and leading to failure" (3, p. 694). What concerns me is that the unthinking, enthusiastic acceptance of unsupported statements that marked the early days of community psychiatry has now turned to equally unthinking disparagement.

Community psychiatry arose from the need to deal with serious gaps in the delivery of psychiatric services. Not so long ago, most of our citizens could not hope to receive treatment for mental illness because of prohibitive costs, scarcity of personnel, lack of facilities, etc. Many of the people who did manage to obtain care were so damaged in state hospitals that they would have been better off with no care at all.

As a result of public and professional concern, new methods of providing services and new treatment approaches were planned, organized, and put into practice. Typically, the prototypes were said to work beautifully, but the later operations did not do so well.

Unfortunately, in their hurry to jump on the community psychiatry bandwagon, psychiatrists as a group proved to be all too human and fallible. They never took the trouble to consider what they were getting into, perhaps because of their hope to wipe out mental illness, the pressure of public demands, or, in some cases, because of the advantages to be gained for their agencies or themselves. Serious attempts to evaluate the effects of the new methods were notably absent from the scene during the 1960s. There was little interest in examining the consistency of the underlying theories or in ensuring that personnel had sufficient training.

Of course, the bubble burst. Now it is easy to say that "they" led us astray. However, the tendency to confuse hopes, beliefs, and prejudices with facts and to proceed to misguided action is a failing that runs throughout the history of psychiatry. Community psychiatry has been far from immune to this unfortunate weakness, but it has not been the only area or even the major area to fall prey to it.

Community psychiatry could certainly have benefited in the early days of enthusiasm from some strong leaders calling loudly for scientific objectivity. Where were the critics then? And what answers do they have now for the problems of inadequate psychiatric services that still exist? Is there any pressure from the critics for an across-the-board evaluation of the effectiveness of all forms of psychiatric treatment so that we can honestly know what we are doing? Or is the current criticism of community psychiatry simply scapegoating? Had the federal government not cut back funding for all sorts of psychiatric activities, would we still be basking in the glow of our presumed but untested invincibility and our unearned public admiration?

We still have some mental hospitals that are barely better than they were 30 years ago. Even among the hospitals that are greatly improved, how many would inspire confidence in us as prospective patients? My guess is very few.

To me, the many needs that are still unmet and the poor quality of the average public psychiatric facility are matters of professional shame. This is all the more so in that most of the recent pressure for improvement has come about not because of the demands of concerned psychiatrists, but because of the demands of patients in court.

Those who would have us forget about the needs of the public while we retreat to the safety of the laboratory and private practice are asking us to give up control of our profession. The need for services and the poor quality of those that now exist will not be forgotten by the public or the government. If we do not exert some leadership, we will be told what to do.

There is more than enough work for us all. I hope that we as a profession can learn some positive lessons from the past. We need to think seriously about why our profession seems to go from one fad to the next with no serious attempt at evaluation. Why do we not use more of the scientific training we all have? Why don't we support evaluation efforts, rather than encouraging the expenditure of millions on approaches that have little more evidence in their favor than faith healing?

Let us continue to work to meet community needs while we strive to raise our standards.

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JACK ZUSMAN, M.D.
Buffalo, N.Y.

Psychiatry Challenged

SIR: Psychiatry has been the harassed camp follower of the therapy faddists and other nonsense-spouting exponents of psychopathological theories for too long. Judge Bazelon ("The Perils of Wizardry," December 1974 issue), not withstanding his simplistic notions of etiology, has issued the profession a challenge. Will we be able to respond intelligently?

KISHORE J. THAMPY, M.D.
Chicago, Ill.

Criminality in the Psychiatric Picture

SIR: The excellent summary of our present situation given by Seymour Kety, M.D., in "From Rationalization to Reason" (September 1974 issue) avoids that aspect of psychiatry where there is, in my opinion, the greatest difficulty—forensic psychiatry. During my 50 years of work in hospitals for psychiatric disorders and in private practice, the problems Dr. Kety points to have seemed most acute and difficult when delinquency and crime are part of the psychiatric picture.

Baroness Barbara Wooton, speaking recently before the Canadian Psychiatric Association and the British College of Psychiatry, stated her view that this problem will not be solved until an institution emerges to fuse hospitals, asylums, sanatoria, retreats, and prisons. She knows of no way to draw a line between them, and psychiatrists have been of little help. I have found that students taking histories miss criminality and delinquency and their part in the total psychiatric picture more often than any other type of relevant fact.

In my opinion, the Kety-Szasz controversy tends to obscure one large sector of our responsibility.

W. CLIFFORD M. SCOTT, M.D.
Montreal, Que., Canada

Ethics in Behavior Therapy

SIR: I enjoyed the timely article by Seymour Halleck, M.D., in the April 1974 issue of the *Journal* on the ethical responsibilities of psychiatric practitioners. However, I thoroughly disagree with his suggestion that traditional psychotherapy has fewer ethical pitfalls than does behavior therapy. Furthermore, Dr. Halleck fails to distinguish between two broad groups of behaviorally oriented approaches that, to me, clearly differ in their potential for ethical problems.

One group of behavior therapies involves the use of operant techniques to subject people (usually large groups) to reinforcement schedules designed to modify their behavior. These individuals are often institutionalized and have no voice in determining what behaviors are considered desirable by the therapist. In these cases, the honest practitioner should admit that he is usually doing his work for the sake of what society as a whole considers to be beneficial.

The second group includes those techniques made popular by Robert Salter, Joseph Wolpe, and others. These are client-oriented therapies in which the patient voluntarily seeks alleviation of personal distress. Dr. Halleck's comments do not apply at all to these techniques, which frequently expand the patient's self-awareness. They give the patient a "meaning" for his symptom. (That the meaning rarely coincides with neo-Freudian theory diminishes neither its honesty of intent nor its utility.) Successful treatment frequently depends on increasing the patient's assertiveness, and the patient is the only person whose welfare is considered when these treatments are carried out.

Traditional psychotherapy, on the other hand, often strongly reflects the theoretical biases of the practitioners. Because these biases are not transmitted overtly to the patient, such therapy can easily descend into an insidious form of thought control.

Nothing I have said is intended to diminish my appreciation of Dr. Halleck's main thrust, which is that we will all do well to review often the moral and ethical dilemmas that confront us in our work.

M.S. RAPP, M.D.
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Combining Antipsychotic Agents

SIR: I am pleased by the increasing interest in combined medical and psychiatric strategies in the treatment of acute psychosis (1, 2). Fortunately, efforts are being made to evaluate the efficacy of the traditionally used low-potency soporific antipsychotic agents and the high-potency antipsychotics that are now available for parenteral administration (3, 4). The initial use of low-potency sedative agents such as thioridazine and chlorpromazine has been emphasized in the past (5, 6). Since insomnia is a frequent finding in acute psychosis, providing sleep has been an accepted immediate chemotherapeutic goal (2, 5). Sedative benefits have been potentiated by using an initial combination of a phenothiazine and a barbiturate (2, 7). This combination is felt to be particularly useful during an acute period when parenteral administration is required and phenothiazine dosage limitations are of concern because of hypotension and other side effects.

As a result of recent interest in the high-potency antipsychotics, we at the University of Chicago Drug Research Clinic have undertaken a preliminary assessment of their use in the treatment of acute psychosis in 32 individuals. Therapeutic goals include 1) return to a level of social and interpersonal functioning that existed prior to the acute episode; 2) combined objective and subjective reports of desirable emotional comfort from the patient, nurse, family, and research team; and 3) the avoidance of undesirable side effects. Patients have received either 5 mg of haloperidol intramuscularly every 4 hours or this dosage of haloperidol in combination with 250 mg of sodium amytal intramuscularly every 8 hours.

Satisfactory results have been obtained for both groups. However, the patients in the combination-drug group attained therapeutic goals earlier and accordingly have required less total haloperidol. The incidence of dystonic reactions in the combination-drug group was 40 percent of that in the haloperidol-alone group.

Hypotension has not been a problem in either group. Following the onset of treatment, the combination-drug patients attained sleep 10–16 hours earlier. The previous feeling that a hypnotic effect is associated with an earlier return to preexisting functioning appears to have merit.

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WILLIAM E. THORNTON, M.D.
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Medical Model in Mental Health Centers

SIR: The categorically descriptive definition of the medical model developed by Frank M. du Mas, Ph.D., in his article "Medical, Nonmedical, or Antimedical Models for Mental Health Centers?" (August 1974 issue) is helpful, but it is restricted because of its relatively fixed structural basis.

A more dynamic and historical approach is necessary to do full justice to the classical medical model. It is a working model of an open system presumably devised by Hippocrates to include all pertinent data on health and illness, and it interacts with other systems.

Different subsystems of the "organized complexity" represented by the medical model can be identified and made the province of a variety of professionals and technicians. However, the comprehensive use of the model requires the educational process that programs the physician to its use and thereby includes him in the system.

The question is not whether we should use the medical model in mental health centers, but rather how it can be used. Its use certainly does not preclude the use of other models that may offer more to a particular applicant for service. This may give the impression that nonmedical models are sufficient to meet the need in mental health centers. However, from my experience, this is an illusion that is shattered the first time an obviously sick person enters the clinic.

SAMUEL R. WARSON, M.D.
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Anticholinergic Action of Thioridazine

SIR: I found Dr. Jonathan Davidson's letter, "Possible Effects of Combining Phenothiazines" (December 1974 issue), most interesting. Thioridazine has the highest anticholinergic activity of the phenothiazines in common clinical use. It has approximately 87 times the affinity for brain muscarinic cholinergic receptors as fluphenazine (1). Also, it is about one-sixth as potent as benztropine in anticholinergic activity (1). At the Psychiatric Research Laboratory of the Massachusetts General Hospital, we feel that the anticholinergic activity of thioridazine

is often overlooked. In fact, we have recently seen cases of anticholinergic toxicity involving thioridazine. These cases were successfully treated with the reversible anticholinesterase physostigmine. Also, thioridazine coma has been reversed by physostigmine (2).

It is quite conceivable that the high doses of thioridazine used with Dr. Davidson's patient could exert enough anticholinergic effect to suppress signs of parkinsonism resulting from fluphenazine. As antiparkinsonian drugs have been shown to depress plasma levels of phenothiazines (3) and to reverse clinical improvement (4), the idea of using anticholinergic phenothiazines to control drug-induced parkinsonism deserves further study.

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LETTERS TO THE EDITOR are welcomed and will be published, if found suitable, as space permits. Like other material submitted for publication, they must be typewritten double-spaced. The letters should not exceed 500 words, including references, unless a special arrangement has been made with the Editor, and they will be subject to the usual editing.

Psychiatric Syndromes and Modes of Therapy. Serial Handbook of Modern Psychiatry, vol. II, *by Jules Masserman, M.D. New York, N.Y., Intercontinental Medical Book Corp., 1974, 184 pp., $14.75.*

In both arrangement and philosophy, this highly readable and informative book resembles Masserman's *Principles of Dynamic Psychiatry* (1), which made such an impact on the psychiatric scene when it appeared almost 30 years ago. Even some of the same case illustrations are used. In both that book and this new one, Masserman deals with psychiatric syndromes in a way that recognizes the existence of and need for diagnostic labelings while also recognizing the fact that patients' problems may encompass more than one diagnosis. Masserman deprecates a "procrustean relegation to iatropoietic categories."

The result of this approach is that each case illustration (there are 47 clinical cases and three that will be mentioned later) mentions the diagnostic categorizations applicable to the syndrome but focuses more directly on the dynamics and on the social, familial, organic, intellectual, and economic elements involved in producing the incapacity that must be dealt with in therapy. The chapter headings therefore offer only general impressions of the material subsumed under them. Patients do not lend themselves to neat and tidy presentations.

There are some concentrated discussions of various problems, but in general the book is to be read through, not handled as a reference work. Used in this way it is delightfully illuminating. In some areas the author exercises his right to digress into areas of his own interest, regardless of their specific application to the matter at hand. His etymologic bent has long been part of his great interest to his readers; he demonstrates it in various parts of this book. His discussion of the various meanings of the word "office" as used by the psychiatrist is a good case in point.

As noted above, three of the case illustrations listed in the table of contents do not concern patients at all but are part of the whimsy that adds zest to the book. One is Theophrastus' description of "The Penurious Man," one is Masserman's now famous "Psychosomatic Profile of an Ingrown Toenail," and one is simply called "Stereotyped Normality." They are all—as is the book itself—good reading.

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C.H. HARDIN BRANCH, M.D.
Santa Barbara, Calif.

Contemporary Issues in Psychiatry, *edited by John G. Howells, M.D., D.P.M. Toronto, Ont., Canada, Butterworths, 1974, 259 pp., $15.40.*

The title of this volume might cause an American reader to expect a treatise on national health insurance, PSROs, interprofessional relations, and the future existence of psychiatry as a profession. However, the book consists of a collection of writings from 1970 to 1973 by a group of progressive psychiatrists in the United Kingdom whose focus is primarily British.

The substance encompasses the major topical aspects of psychiatry, including clinical, nosological, educational, administrative, and architectural issues. The individual sections reflect a high degree of scholarship and professional concern as well as a thorough coverage of the categorical concept. They lack only that redeeming British wit and humor which we Americans have come to expect.

In spite of its emphasis on areas of British concern, the material has substantial pertinence for psychiatry in the United States. Indeed, the section on medical administration in psychiatry, which reflects the problems of a nationally operated mental health system, may very well represent a precursor and a warning of what this country can expect under national health insurance. The only quasi-socialized system of medical care in the United States is that provided by the state hospital system. In spite of the apparent problems in our system, it lacks many of those described as occurring in the British federally operated system.

In the clinical section of the book there is strong advocacy for reuniting psychiatry with the mainstream of general medicine, in terms of both clinical practice and psychiatric training. The recent trend toward broadening the practice of child psychiatry to that of family psychiatric practice receives full exposition in a lengthy section written by the editor, Dr. Howells. An excellent plan for organizing the mental health services for delivery to the aged mentally ill is also presented. This scheme retains a very practical approach toward idealized goals.

The only section that gave me pause was that on the nosology of psychiatry, which, in spite of its linguistic erudition, reflected shades of Adolf Meyer. For example, I find it a little hard to believe that the practicing psychiatrist will find it easy to evade traditional habit and substitute "encephalo-ataxia" for the term "schizophrenia," in spite of the legitimate Greek derivation of the former term. Just as torturous would be the attempt to substitute "encephalo-lampsia" for the commonly used term "mania"—not to mention the typesetting problems that would arise for psychiatric publications. Nevertheless, the logical argument for more precise diagnosis and appropriate changes in the nomenclature is well worth the short time necessary to review this section thoroughly.

I would strongly recommend the section on neglected aspects of psychiatric education to those medical schools which have instituted crash programs for early specialization. I would also recommend comparisons of the American scene with the British scene to all directors of psychiatric residency training programs.

Although the author of the portion of the book directed toward medical administration in psychiatry attempts to maintain his objectivity, it becomes very obvious that he is sorely troubled by the complexity, the frustrating bureaucracy, and the major conflicts in the administrative organizations associated with the national health service.

The remainder of the book is composed of two excellent sections on architecture. These present a variety of psychiatric programs that would be of value to those planning new or ex-

panded psychiatric facilities and for those state services now modifying or renovating their physical plants.

Each section of this book contains an exhaustive bibliography. All in all, I would recommend this small volume as an eminently readable reference work as well as a harbinger of things to come.

JAMES C. JOHNSON, M.D.
Hartford, Conn.

Rational Hospital Psychiatry: The Reactive Environment, *by Jerrold S. Maxmen, M.D., Gary J. Tucker, M.D., and Michael D. LeBow, Ph.D. New York, N.Y., Brunner/Mazel, 1974, 274 pp., $12.50.*

The voices of reason and humanity, which are required for patient care and treatment, frequently get lost in the community clamor associated with the changing or closing of state hospitals. Beleaguered hospital staff members are hard pressed to plan, deliver, document, and monitor care and treatment efforts and to move prepared patients into prepared communities. Much of the present literature focusing on social and institutional change fails to deal with the important grass-root issues that are the ultimate objects of change.

This book comes as a timely and reasonable antidote. It is concerned with improving inpatient services at the service delivery level and offers very practical suggestions for the harried clinical staff.

The core theme is that of the reactive environment required in the inpatient unit. This is best described in the authors' own words:

> A reactive environment [is] one in which the unit's overall structure maximally utilizes and coordinates the entire staff's efforts toward the rehabilitation of the patient's particular behavior problems so that ultimately he becomes a long standing and productive member of society. (p.33)

Types of reactive environments are described, including a lucid consideration of the token economy. In this context emphasis is placed on what a patient does rather than on what the patient is—an indication of the book's message that a rational and scientific detailing of the patient's behavior beyond traditional diagnostic labeling leads to an appropriate and constructively reactive milieu.

In their consideration of the hospital as a system, the authors detail specific problems and make specific procedural suggestions as they follow the patient through the system from admission and treatment through discharge planning and community placement.

The chapter on the use of medication exemplifies the book's approach to hospital psychiatry. Avoiding the use of specific drugs, the authors choose to point out the rational use of medication: all team staff need to know about the use of medication because staff attitudes toward the use of medication can influence the patient's clinical response. Chapters on family involvement, training, recordkeeping, and planning for aftercare should offer help to hospitals in the throes of change.

I would like to have found more of the authors' ideas on the rational use of crisis intervention as well as their concepts of the rational place of inpatient services in the context of a broader mental health delivery system—including outpatient and partial hospitalization services.

However, the book does deliver very well what its title promises. The concepts and methods presented are rational, timely, and clearly expressed. It succeeds in integrating concepts and methods of concern to all disciplines on the treatment team.

This book is an important addition to the literature on state hospital change.

JAMES W. DYKENS, M.D.
Concord, N.H.

Practical Clinical Psychopharmacology, *by William S. Appleton, M.D., and John M. Davis, M.D. New York, N.Y., Medcom Press, 1973, 162 pp., no price listed (paper).*

This little handbook is part of a series intended for rapid communication of current medical information. It deals with the clinical application of psychopharmacology and is addressed to "the practicing physician-psychiatrist and medical student." One of its purposes is to differentiate "fact from fiction when prescribing psychotropic medication."

On the whole, the book is fairly well done; it is a useful addition to what has been available, particularly for the practicing physician, the resident in psychiatry, and others interested in psychopharmacology. In a simplistic but reasonable way, it covers many aspects of psychopharmacology and deals with the major categories of useful pharmacotherapeutic agents. In this area it succeeds admirably in its aim. Its virtue is the brief, accurate, and simple way that it conveys this information.

However, because it is a small volume, it is less successful when it attempts to summarize clinical psychiatry to provide a background for the use of psychotropic agents. The book might have been better in this area if it had omitted this section, which becomes a reductionistic attempt to squeeze psychiatry into a small format and add psychopharmacology to it. In short, if the book can be criticized for a shortcoming, it is that its psychiatric summaries are reductionistic and thus inadequate.

This, however, is a minor carp if one looks at the main purpose of the book, which is to convey psychopharmacology in a simple form. In the hands of experienced teachers, residents in psychiatry, or others who are learning or who have learned their clinical psychiatry more thoroughly elsewhere, it is a valuable book.

I recommend this volume to those who want a cogent, precise summary of many of the main findings of current clinical psychopharmacology. There are some points one could quibble about, but this in no way detracts from the basic merits of this concise, practical summary of psychopharmacology. It can also be used as a handbook companion to some of the larger psychopharmacological textbooks in the teaching of psychopharmacology.

G.J. SARWER-FONER, M.D.
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A Home for the Heart, *by Bruno Bettelheim. New York, N.Y., Alfred A. Knopf, 1974, 461 pp., $12.50.*

In his introduction to this book Dr. Bettelheim states,

> This book consists of four unequal but closely interrelated parts. The first is a discussion of the physical setting within which the institutional life proceeds. The second is an account of total residential therapy as it evolved over some twenty-seven years. The third and fourth parts

discuss, in detail, how the staff operates and how its training is carried out. (p. 13)

The setting is, of course, the University of Chicago's Orthogenic School for autistic and schizophrenic children. Dr. Bettelheim, a well-known lay analyst, has written extensively on the topic of the school. Having recently retired after many years as its director, he attempts in this book to present an overall view of its program.

It appears that the author tries to place the philosophy of the school within the historical background of nineteenth-century moral treatment in the United States and the psychoanalytic movement. Both of these trends have by nature resisted any attempt at categorization and objectification; each therapeutic program influenced by these trends has tended to remain unique—to be an isolated expression of a particular charismatic leader.

This feeling of uniqueness certainly permeates Dr. Bettelheim's book. There is much to be admired in the feeling that comes through in his description of the school—the dedication of the staff, the reciprocal support among staff members (especially when exposed to the psychotic behavior of the patients), and the characteristics of the physical setting, particularly of the "living room," bathroom, staircase, and grounds. Also impressive are the analogies brought forward between a treatment center and a monastic setting or a spa as well as some of the more clinical discussions—notably the lengthy one on empathy.

On the other hand, many readers might be troubled by more than one point in this book. The author almost completely disregards the parents of the children in treatment. He seems to view them as the perennial villains of the play: they are never consulted, emphathized with, or considered as worthy of respect as their psychotic children. It appears to me that Dr. Bettelheim's statement that "we try to convince the parents that they must be satisfied with the thought that they have done the very best for him [the child]" (p. 183) seems meaningless. Another distressing facet of the book is the overt or covert criticism of other professionals. Dr. Bettelheim states that "we would never believe that somebody else has a deeper understanding about what is good for us than we do" (p. 180).

The repeated statement that everybody is equally important at the school is at variance with the conclusion of the distinguished sociologist Jules Henry (1). He defined the school's system as "simple undifferentiated subordination." The book also lacks clarity in defining such terms as "senior staff members," "consultants," "superiors," "psychotherapists," and "individual psychotherapy." This seems strange in a book that gives more than 100 pages to a description of the physical setting.

Do the results justify the program carried on at the Orthogenic School? We are told,

> Better than 85 percent of those with whom we worked have been restored to full participation in life .... Among the more than two hundred former patients are pilots of commercial airlines, social workers, journalists, nurses and professors of nursing education, businessmen and bankers, but also some master barbers, construction foremen, and secretaries. (p. 13)

These are about all the data we are given showing the success of the school. This seems inadequate in our age of sophisticated methods of data collection.

This last point raises the question of whom the book is written for. I would guess that it is not written for parents or for former patients. Various professionals as well as nonprofessionals working with very disturbed children can certainly find in it new incentive for their daily labor, but it is questionable that the experience of the Orthogenic School can be repeated elsewhere. It does not seem unlikely to me that Bettelheim wrote the book mainly for himself, as a way of facilitating a difficult separation from the program he built and loved so much.

Regardless of his motives, Bettelheim's work should be placed in the proper developmental perspective: that is, a very comprehensive attempt at the psychoanalytic treatment of psychotic children. In the light of today's upsurge of behavioral therapy and the involvement of parents, such treatment can be considered as essentially too unilateral or, for some, as nostalgia for things past.

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The Psychological Sense of Community: Prospects for a Community Psychology, *by Seymour B. Sarason. San Francisco, Calif., Jossey-Bass, 1974, 285 pp., $12.50.*

Dr. Sarason addresses many critical issues that require study, discussion, and action if the movement of the past 15 years toward community-based care is to flourish and maintain its viability. The book is written in the context of psychology but has equal relevance for psychiatry. Dr. Sarason issues a challenge to all mental health professionals who have moved into the community in the following statement:

> Although by and large [the] community psychologist [has been] dealing with individuals, groups, and problems that were long neglected ... he has dealt with them as if he was to pour old wine into new bottles. (p. 151)

In this illuminating, challenging, and well-written work, Sarason takes to task those in his own profession of psychology and, indirectly, all other mental health professionals who have chosen to work in the community for their neglect of the importance of the psychological sense of community. He feels that the dilution or loss of this community sense is "the most destructive dynamic in peoples' lives" (p. viii).

He argues that the development of a psychological sense of community should be the keystone value motivating not only community psychologists but all mental health professionals attempting to assist people to remain in their communities. In the most persuasive part of this book, Sarason calls attention to how the setting up of community "institutions," although they remove people from state institutions, can further diminish the psychological sense of community because they "rob the community around them of an opportunity to reinforce the psychological sense of community among its members" (p. 162). He cites lengthy descriptions of special classes in our educational system, mental retardation centers, and detention institutions for juveniles as examples of what he calls "humane segregation."

On the positive side, he also argues persuasively for the potential that halfway houses have for reinforcing the psychological sense of community. However, in his opinion, they have

failed to reach their potential because they usually serve as a mechanism for removing people with abnormal behavior from the community and thereby perpetuate humane segregation.

Sarason's powerful arguments for the integration of those with abnormal behavior into the community to preserve the psychological sense of community are somewhat diluted by his failure to address the dynamics that affect most individuals' reactions to abnormal behavior. He does not seem to recognize the increased anxiety in normal individuals, which tends to play a role in the development of these programs and institutions.

While one can accept his argument that there can be no true psychological sense of community until humane segregation is eliminated (p. 173), I find it difficult to accept Sarason's contention that the complete elimination of humane segregation is a realistic goal. Within the current context of the often vehemently negative reaction of many toward those who have been discharged from the state hospital into the community without aftercare, it is hard to conceive of the development of a complete psychological sense of community.

Despite these criticisms, the basic theme of Dr. Sarason's book—that all mental health professionals who work in the community, including psychiatrists, must pay more attention to community processes and dynamics—is valid. He is also particularly forceful when he calls attention to the failure of community psychology and psychiatry to turn more toward prevention. However, like other authors, he does not offer any concrete suggestions as to how primary prevention might be accomplished.

Sarason is also on target when he criticizes academia for its isolation from the community and when he describes the defensiveness apparent in the failure of many academicians to appropriately engage with lay members of the community in the planning and the delivery of services.

Dr. Sarason, who is the director of the Yale Psycho-Educational Clinic, has provided a useful service by once again focusing our attention on the need for those of us who are actively engaged in the delivery of services to disturbed individuals within the community to pay more attention to community processes and characteristics. Although these social characteristics may appear to lack psychological substance, they have very important psychological consequences for the progress of our patients. Our failure to take these factors into consideration can be legitimately criticized. Dr. Sarason has written one of the most lucid criticisms of this failure to date.

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The Child in His Family: Children at Psychiatric Risk, vol. 3, *edited by E. James Anthony, M.D., and Cyrille Koupernik, M.D. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 544 pp., no price listed.*

This is the third volume in a series of yearbooks of the International Association for Child Psychiatry and Allied Professions published by John Wiley & Sons. The editors of all three volumes are E. James Anthony of St. Louis and Cyrille Koupernik of Paris. The first two volumes were titled *The Child in His Family* (published in 1970) and *The Child in His Family: The Impact of Disease and Death* (published in 1973). The editors were assisted by an editorial board of child experts from countries all over the world.

The content of this third volume is divided into three sections and preceded by a foreword by Bertram S. Brown, M.D., Director of the National Institute of Mental Health.

The first section, titled Theory for a New Field, is made up of five articles. The second section deals with articles presented at the Bled Conference in Yugoslavia in July 1972. The third section deals with papers presented at the Dakar Conference in Senegal, Africa, in the summer of 1973. In addition to the various papers, there are discussions by various invited participants from different parts of the world.

It is difficult to single out the most important papers contained in this volume in a brief review. The articles cover the entire field of childhood psychopathology. There are also articles dealing with site visits by English-speaking and French-speaking groups. I found the anthropological and sociological studies, including the study on child-rearing practices in various African cultures, to be most informative.

An advertisement with reference to the publication of this volume describes quite accurately my reaction to this work:

> These volumes present the family as a changing entity acted upon by industrialization, war, social movement, disease, and more .... They give you a better picture of how the family affects the child.

This volume alerts the child psychiatrist to the growing risks of life today and to the special vulnerabilities of particular children to these risks. It also discusses how to prevent the development of psychological disorders in vulnerable children by reducing the degree of risk they are exposed to.

I recommend this volume to all professionals who deal with children. This includes not only psychiatrists, psychologists, and social workers but also such professionals as teachers and probation officers.

FRANK J. CURRAN, M.D.
New York, N.Y.

Questions and Answers on Death and Dying, *by Elisabeth Kübler-Ross, M.D. New York, N.Y., Macmillan Publishing Co., 1974, 171 pp., $4.95; $1.50 (paper).*

From antiquity, physicians have endeavored to relieve the suffering of dying patients and to provide them with what for centuries was called euthanasia. This Greek term originally referred to a good or peaceful death and included the medical art of accomplishing easy dying. First used by Emperor Augustus, the word retained its original meaning until the end of the nineteenth century, when it began to be used to refer to mercy killing.

In recent times, the healing professions have seemed neglectful of the noble art of euthanasia according to its original meaning. Armed with the achievements of modern science and technology, we have joined with society at large in attempting to escape the reality of death. A conspiracy of silence has surrounded the dying patient as an endless succession of new treatments has prolonged his demeaned existence.

Since the appearance of her book *On Death and Dying* (1), Dr. Kübler-Ross has become the foremost spokesman of merciful ministry to the needs of patients facing death. She is a modern-day good Samaritan in her advocacy of a compassionate response to their suffering. While many professionals have passed by on the other side of the road, Dr. Kübler-Ross has stopped to offer her unselfish care and concern.

Dr Kübler-Ross' message, which she presents again in *Questions and Answers on Death and Dying*, is simple and direct: although dying patients threaten our sense of immortality and omnipotence, we must not avoid them. Since most dying persons are aware of the seriousness of their illness, we must be

prepared to talk with them about it and accept their expressions of grief and rage. Dr. Kübler-Ross feels that genuine compassion and courage are adequate preparation for encounters with the fatally ill, encounters in which words may give way to shared silence and jointly held hope for this life may be relinquished. She also tells us that if we are patient we will see many persons who, as their energy declines and they sever ties with the world about them, progress from stunned disbelief to a welcome acceptance of the death that awaits them.

Dr. Kübler-Ross' book is directed toward paraprofessionals; they should derive guidance and inspiration from it. Written in a question-and-answer format, it is somewhat fragmented and repetitious. However, the questions are those most frequently asked about death and dying, and they pose a great variety of challenging and poignant situations.

Dr. Kübler-Ross has aroused us to the needs of dying patients and reintroduced us to the ancient and noble art of euthanasia. Her latest communication is welcomed in this light. If she has improved our care of these patients, perhaps she has also helped us to become more aware of our own mortality and more humble regarding the medical skills at our command.

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RUSSELL NOYES, M.D.
Iowa City, Iowa

The History of Childhood, *edited by Lloyd deMause. New York, N.Y., Psychohistory Press (Atcom), 1974, 431 pp., $12.50.*

This history of childhood in Western civilization is the product of a collaborative research project begun six years ago under the auspices of the Association for Applied Psychoanalysis. Each of the 10 contributing historians sought "to reconstruct how parents and children related to each other in different time periods and different countries." They have assembled a good deal of useful, fascinating, and relevant material from very diverse sources.

Infanticide, child abandonment, the use of wet nurses in and out of the family home, fosterage (sending seven-year-old children to be raised as servants in the homes of others), and swaddling are some of the topics discussed. For the most part, these are handled well and thoroughly. Affectional and intimidating parental attitudes through the years are also described, together with some of the factors tilting the scales in one direction or the other. I learned a great deal from these descriptions.

Ross's chapter on middle-class children in urban Renaissance Italy is a model of what psychohistory should be. Data and conclusions are presented simply, clearly, and without jargon; the questions emerging from the study are offered similarly. Also excellent is Tucker's description of childhood in fifteenth- and sixteenth-century England, which points out that men were not permitted in delivery rooms until the middle of the sixteenth century. The chapters by Marvick and by Illick on childhood in seventeenth-century France and seventeenth-century England and America, respectively, are also well worth reading. Dunn's chapter on imperial Russia has a splendid short section on the upbringing of several key literary critics, the ideological forebears of the revolt there against autocracy.

The other chapters all present valuable data, but a few are marred by unprovable and essentially meaningless psychological speculations like the following:

> Who can say whether or not Esther Burr, wife of the president of Princeton College, was entirely free from destructive motives when she took her little baby, Aaron, age about 11 months, on a long and dangerous trip ... from which he nearly died? (pp. 352, 353)

Greater knowledge of religious history, particularly of the Pauline antisexual counterreaction to Greek pansexual promiscuity, might have strengthened the book. Editor deMause's first and lengthy chapter, "The Evolution of Childhood," would have particularly benefited by such knowledge. By the same token, a greater awareness of the naïve religious historians of the late nineteenth century, who evaluated pre-Christian religious data primarily as foreshadows of the true Christian faith, might have reduced deMause's tendency to see psychoanalytic explanations as veritable ultimate answers rather than as important illuminations.

This book belongs in medical libraries. Some of its chapters and sections should be read by all those who are interested in the history of parent-child relationships. I look forward to further work from these authors and hope that their future contributions will separate more clearly the valuable facts they have unearthed and the speculations and concepts based upon them from what sometimes appears like arbitrarily imposed theory.

NATHANIEL S. LEHRMAN, M.D.
Roslyn, N.Y.

Remember Maria, *by John G. Howells, M.D., D.P.M. Toronto, Ont., Canada, Butterworths, 1974, 115 pp., $2.50 (paper).*

Maria Caldwell was battered to death by her stepfather while she was in his and her mother's care after having been in the care of foster parents for six years. This book is Dr. Howells' chilling brief remembrance of her life and death; it is also a lesson, if it will be learned, to all in and out of the health professions whose decisions determine life, death, or a living hell for Marias everywhere.

Dr. Howells gives brief vignettes of many other instances of child abuse that have resulted from administrative, legal, and bureaucratic insensitivities. He is specifically concerned that many children are at risk in their own homes, as was the case with Maria. Child authorities lean on the established opinion that there is an ever-present strong bond between child and mother. It is one of the main objectives of this book to show that this bond is not always present.

Child-care procedures are for the benefit of the child, not the child-care authorities. Howells challenges the many assumptions—tacit and overt—that govern our attitudes and actions about the rights of children, the rights of natural parents, and the rights of foster parents. He especially challenges the assumption that natural parents should have the upper hand in managing their children even when this is inappropriate or, as in Maria's case, dangerous.

Howells elaborates on the basic misconceptions that killed Maria and many other children. The first misconception is that the link between natural parent and child is of such value to the child that it outweighs all other considerations. For Maria the determination was made that this link had to be maintained with her natural mother even if this meant that she would be with an abusive stepfather and be separated from a caring natural aunt.

The tie of blood is often given overriding importance in legal proceedings—to the detriment of the child. The battered child is the tip of the iceberg of child abuse. Only a small minority of children are physically battered; many more suffer from psychological neglect and abuse. Howells emphasizes that the parent-child bond is not mystical or ever present. There are various capacities for parenting; each situation must be assessed as it is.

Howells does not consider the mother-child bond as unique. He avers (as though anyone would quarrel) that the father is central to that relationship too. To understand where we have gone wrong, Howells feels that we have to turn to psychoanalytic theory. He is especially critical of the view that a child needs a continuous relationship with one object in his earliest years. The mother-child relationship is indeed central in psychoanalytic developmental theory because there is satisfactory evidence that from this close and trusting early tie the child develops the capacity for other relationships. Such a view neither denies nor minimizes the relationship of the father or of the rest of the family. Howells asserts that fathering is as significant an element in family life as mothering, but he seems to feel that current psychoanalytic theory and practice are inimical to this view.

The final misconception referred to is that separation and deprivation are synonymous. Howells emphasizes the fact that a child can be psychologically deprived while not separated from his parents and, conversely, can be separated from his parents and not be psychologically deprived. Again, psychoanalytic theory is held responsible for this misconception. Howells is so entirely reasonable in his points of view that it seems all the more strange that he seeks to belabor psychoanalytic views, which in many respects are not too different from his own. A major exception in this regard would surely have to be his blind spot about separation anxiety.

Howells advocates evaluation, diagnosis, and treatment of the entire family unit when the issue of child abuse is involved. If treatment measures fail, separation of the child from the family has to be considered as a therapeutic modality. Howells also calls for increased sensitivity in and restructuring of the legal, bureaucratic, and agency policies with which cases of child abuse inevitably become entangled.

JACOB SWARTZ, M.D.
Boston, Mass.

Dreams and Nightmares: A Book of Gestalt Therapy Sessions, *edited by Jack Downing, M.D., and Robert Marmorstein. New York, N.Y., Harper & Row, 1974, 186 pp., $6.00; $1.50 (paper).*

This is a book of 14 Gestalt therapy sessions transcribed from tape recordings in which patients, friends, and colleagues of the therapist work on their dreams. The sessions appear in the form of dialogues with some editorial comments interspersed. They occurred during short workshops, extended group psychotherapy sessions, and in such unique settings as a patient's apartment. The verbatim style of presentation is that typically used by Gestalt therapists. The late Fritz Perls wrote the introduction to explain how Gestalt therapists work with patients.

No information is provided as to how the dreams presented were selected; each dream is from a different patient. These individuals appear to be office neurotics and individuals seeking personal growth experiences. Dr. Downing serves as a guide, leading each patient through enactments of the images in dreams. The guidance reflects Dr. Downing's theoretical orientation, which is based in Gestalt therapy but includes a variety of existential concepts, psychoanalytic derivations, and some less familiar ideas garnered from his experiences with Sufism and Eastern religion. The work is presented in the human growth and potential framework rather than according to more traditional psychotherapies.

In the preface of the book Mr. Marmorstein, who has participated in a number of Dr. Downing's workshops, explains that he was so impressed with his workshop experiences that he wished to share them with others. He not only describes the personal qualities that he feels make Dr. Downing effective as a therapist but also briefly reviews Downing's medical, psychiatric, and humanistic psychology experiences. The reader will be interested to note that Dr. Downing is best known for his work in comprehensive community psychiatry and the epidemiology of mental disorder. Following Mr. Marmorstein's preface, Dr. Downing reviews some of the major conceptual components of Gestalt therapy that he uses.

The therapeutic method illustrated here is the one pioneered by Fritz Perls and described in his books *Gestalt Therapy* (1), *Gestalt Therapy Verbatim* (2), and, more recently, *The Gestalt Approach & Eye Witness to Therapy* (3). The strategies focus on the here and now, memories and fantasies are enacted as though they were occurring in the immediate present. The purpose of this approach is to heighten emotional experience and to encourage a patient to identify fully with each of the fragments of his life as they emerge into awareness. The underlying concept is that personality change occurs not by reconstruction of the past but through an identification with the ever-changing pattern of perception and behavior.

When conflicts appear in the psychotherapeutic process, as they inevitably do, they are enacted as a psychodrama in which the patient takes both roles in a dialogue, one at a time; the two sides "talk to each other." This often leads to a new integration of the warring elements of personality. At various times the therapist encourages the patient to take an opposite stance to the one that he is espousing; this occurs when the therapist notes that the patient's position seems particularly overdetermined.

The use of an empty chair as a locus for the projection of intrapsychic components is Dr. Downing's standard procedure, as it was Perls's. In these strategies and tactics, one often sees dramatic catharses and unexpected realizations. Such is the case in many of the dreams of patients revealed here. To Dr. Downing's credit, however, the dreams he chose to include do not all reveal successes. Some are more mundane examples of the slow, often routine experiences that are part of psychotherapy.

The book is an honest attempt to reveal without justification what one therapist does with patients. The dreams include only the briefest background data so that in order to find meaning in the dreams the reader must share the perspective of the editors and the "Gestalt" from which they work.

The work will not stand the light of rigorous scientific scrutiny. Rather, it shows some fragments of interaction within a particular framework. As a result, those who share the Gestalt perspective are likely to be impressed by the work; those who do not share this perspective (probably the majority of psychiatrists) are likely to find the information incompatible with their theoretical model. Unfortunately, there is little communication or understanding between those who embrace the medical treatment approach in psychiatry and those who are in the third force of humanistic approaches. Psychotherapists remain divided, like most of our society, into what John Gardner called "unloving critics and uncritical lovers." This division deprives those in one camp of the gains made in the other.

It is well to remember John Stuart Mill's observation about the limits of any conceptual model: that every concept is correct

in what it affirms but wrong in what it ignores or denies. The reader may be surprised to find that although Gestalt therapy has been primarily identified with the humanistic psychotherapies conceptually, it has strong kinship with the medical prescriptive approaches in practice. The therapist offers direct suggestions of exercises for the patient to use in exploration in both types of therapy.

The working alliance that is so essential to any successful therapy is facilitated in Gestalt therapy by the therapist's encouraging the patient to "play" with the elements of his conflict while at the same time insisting that the choice and the responsibility for following these directions reside with the patient.

It is unfortunate that those in humanistic psychology and Gestalt therapy often must rediscover many of the basic truths learned long ago in more traditional therapies. It is as though, in rediscovering everything themselves, they must recapitulate all the errors of the past. Gestalt therapists would do well to read the psychoanalytic literature, especially some of the newer ego psychology developments.

It is equally unfortunate that the biases of psychoanalysts and other therapists are such that they are unable to benefit from reading the developing literature in Gestalt therapy. Here they could find technical devices and concepts that would materially enhance and broaden their own framework. Perhaps we are approaching the day when psychiatrists will be able to incorporate ideas and techniques from a range of therapies without feeling that they are abandoning their theoretical position or becoming alienated from their reference group.

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Alfred Adler: His Influence on Psychology Today, *edited by Harold H. Mosak. Park Ridge, N.J., Noyes Press, 1974, 306 pp., $12.50.*

This book contains 31 contributions by 32 Adlerians on a wide variety of subjects. It is divided into seven sections. The first consists of a memorial to Adler by Marguerite and Willard Beecher to commemorate Adler's 100th birthday. Sections on Theory, The Neuroses, Therapy, Education, Social Issues, and The Humanities follow.

Thirty-seven years after the death of Alfred Adler, one of his original theoretical triumvirate of early psychoanalysis, individual psychology, appears to be alive and well.

Approximately one-third of the contributors to this volume, such as Paul Brodsky, Asya Kadis, and Danica Deutsch, are Europeans who were students of Alder. Most of the remaining contributors are Adlerians who were trained in the United States, e.g., Harold Mosak, Harry Elam, and Robert Powers.

The topics of this volume are quite diverse, ranging from such traditional subjects as "The Private Logic" by Rudolf Dreikurs to such unexpected chapters as "The Young Hooligan" by James Hemming and "The Cartoon as Therapeutic Catalyst" by Asya Kadis and Charles Winick.

There is of course a variety of writing styles and idiosyncratic points of view. For the casual reader the book might appear to be an entirely eclectic potpourri of information and points of view, e.g., "Sociometry of the Family" by Adlerine Starr, "The Psychology of Addiction" by Donald Lombardi, and "The Psychology of Prejudice" by Lewis Way. However, for the discriminating reader who is sensitive to the various currents of thought in the application of psychology to human problems, each of the articles is entirely consistent with the central theoretical-philosophical tenets of Adler's individual psychology as a teleological, holistic, field-theoretical, phenomenological, and socially oriented point of view.

The reader may also realize that each of these articles appears to be of the commonsense variety. None of them appears to be representative of a particular school of thought. This is almost a central paradox of Adler's individual psychology: what appears to be just plain horse sense is very clearly distinguished from other points of view that emphasize such elements as the dualism of mind and body, the importance of conditioning, and the effects of society and heredity in determining behavior. These elements are strongly rejected by Adlerians.

Adler's individual psychology, with its strong social orientation, its insistence on the integrity or indivisibility of the individual, its assumption that the proper position to view people is from their individual points of view, and its proposition that future goals rather than past experiences determine behavior, is well represented by the various articles in this book.

At the present time, there is no completely satisfactory book about individual psychology for the general layman or for the mildly interested professional, but Mosak's book appears to be the volume of choice for a comprehensive picture of Adlerian individual psychology in action.

Well edited and fairly comprehensive in its coverage, it is an easy book to read and will be of interest to a wide spectrum of readers. It should also help expand the interest in individual psychology that has been growing at an accelerating rate in recent years.

RAYMOND J. CORSINI, PH.D.
Honolulu, Hawaii

The Fear of Looking or Scopophilic-Exhibitionistic Conflicts, *by David W. Allen, M.D. Charlottesville, Va., University Press of Virginia, 1974, 128 pp., $7.95.*

This book is a slender but remarkably comprehensive volume on the phenomenon of voyeurism and its counterpart, the "fear of looking." This active-passive duality has been part of man's repertoire of instincts since the beginning of mankind. It was evident in man's first artistic representations of other human beings, in the wave of modesty that came over ancient heathen statuary when figleaves made their appearance to cover the genital zones, and in modern society's debates on the esthetic merits of nudity on the beaches and pornographic moving pictures.

Although both the sexual pleasure and the fear of looking exist to some degree in all people and have always been present, Sigmund Freud seems to have been the first to find descriptive terminology for the complex. More specifically, Freud described the neurotic conflicts and consequences arising from the violation of the "looking-and-showing" interdictions. It may be for this reason that Dr. Allen, a psychoanalyst, felt particularly attracted to the study of the looking-showing phenomenon.

Dr. Allen illustrates his discussion with the clinical data of a dozen case histories from among his own patients who suffered from the neurotic consequences of their unresolved scopophilic-exhibitionistic conflicts. Apart from his profound and convincing clinical insight into the consequences of the sco-

pophilic-exhibitionistic conflicts, Dr. Allen also offers a rich panorama of illustrative material from anthropology, the history of art, and belletristic and psychoanalytical literature.

It is only after completing the study of this volume that one becomes aware of the all-pervasive fear and love of looking, both of which govern so much of what is common human behavior, regardless of the almost total absence of voyeuristic tendencies in women.

ILZA VEITH, PH.D.
San Francisco, Calif.

Child Psychiatry for Students, *by F.H. Stone, M.B., Ch.B., and C. Koupernik, M.D. New York, N.Y., Longman, 1974, 105 pp., $4.00 (paper).*

Drs. Stone and Koupernik, two experienced child psychiatrists from Glasgow and Paris, respectively, have composed a most useful distillation of the principles of child psychiatry for medical students and other beginning trainees. This slim volume is the right size to accompany the student as he or she first arrives on a child psychiatric service.

The authors' European orientation is not a serious obstacle for the student in America. In fact, their lucid presentation is good evidence of the high level of current transatlantic communication. The authors convey a mature wisdom and humanistic respect for the person as they approach the problems of troubled children and their families.

The coverage includes all major topics of significance, ranging from a précis of normal child development through discussions of diagnostic categories, assessment, and treatment techniques. Certain elements are necessarily skimmed (as in the chapter on organic syndromes). Other sections, such as the one on psychotic and autistic states, are somewhat incomplete.

For the most part, the authors have done a masterful job in compressing a great deal of knowledge into a brief text. It is clear from the special nature of the presentation that they intend that the book be studied under the direction of a tutor and in connection with the first clinical exposure to child psychiatry. When used in this way, the volume will serve a most useful purpose.

PAUL N. GRAFFAGNINO, M.D.
Hartford, Conn.

The Psychology of Leisure: Research Approaches to the Study of Leisure, *by John Neulinger. Springfield, Ill., Charles C Thomas, 1974, 203 pp., $9.75.*

Most students of the psychology of leisure quickly reach the point of deploring the lack of hard data on leisure and emphasizing the necessity for extensive research on which to base conclusions. Thus a book that promises to fill the void is approached with eager anticipation.

Unfortunately, what one rediscovers in this book is the difficulty in even defining the term "leisure," let alone coming up with a valid theory of leisure. The complexity of the problem was well stated by Kaplan: "Ultimately a theory of lesiure can be little less than a theory of man and a theory of the emerging culture" (1, p. 289).

An adequate conceptualization of leisure is a sine qua non for any research on the topic. Rather than providing such a conceptualization, Neulinger lists a number of definitions of leisure, includes an excellent paradigm of his own, describes differences in various concepts of leisure, and delineates some of the meanings implied by the word itself.

He resolves the dilemma about research on leisure by narrowing his goals, restricting his research to the study of specific aspects of leisure. He delineates meaningful dimensions in the leisure domain that are susceptible to investigation and, perhaps, experimentation.

It is interesting and understandable that this book by a research psychologist about doing research in the field of leisure has a missionary, nonresearch goal. It was written with one overriding purpose: to help restore leisure to its rightful place—to show that to be at leisure is to become oneself and to be oneself. Neulinger hopes to redefine leisure in such a way that society can proudly and openly acclaim once more that it is the ultimate goal.

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PETER A. MARTIN, M.D.
Southfield, Mich.

Adolescence: Psychology, Psychopathology, and Psychotherapy, *by Derek Miller, M.D. New York, N.Y., Jason Aronson, 1974, 529 pp., $15.00.*

Although somewhat uneven, this book unquestionably represents a solid contribution to the literature on adolescence. It is unusually comprehensive, thoughtful, and sensible as well as well indexed and cited. It also contains helpful case examples throughout. Dr. Miller, who trained both in England and in the United States, has published widely in his field; he draws heavily on his clinical experiences in the case vignettes.

Miller favors a traditional psychotherapeutic approach. He warns of the appeal of behavior modification techniques as employed by teachers who can then ignore "the dynamic subtleties of interpersonal relationships." He also cautions against placing too much reliance on family therapy as the sole approach to adolescents because of the inevitable conflict of interest present between the adolescent and his family. Throughout the book there is a strong emphasis on the adolescent's need for external controls—controls tempered, however, by mutual respect rather than predicated on fear.

The author's avoidance of jargon and his clarity make this a superb book for those laymen who deal with adolescents—teachers and school administrators in particular. Even architects and city planners will find excellent suggestions regarding adolescents' needs. Any parent should profit from a careful reading of the book, not only to understand his child better but also for the insights he will receive about his own psychic life. The section on death and divorce and the ones on drug abuse are particularly excellent for all readers.

In my opinion, the principal flaw in the book rests with its style more than its philosophy. It is a rather ponderously written book. The author uses too many words to say too little; yet, paradoxically, his case examples are often too abbreviated. He has organized his chapters and subchapter headings in such a way that repetitiousness is inevitable and annoying. One example of this is the paragraphs that are repeated verbatim on pages 520 and 521 and pages 514 and 515. (This may have been a printer's error.)

This book also seems curiously dated on the subject of

women's liberation. Although Miller refers to the changing roles of the sexes he still makes such statements as the following:

> A boy proves his masculinity away from home, primarily with male friends, with girlfriends, and finally with economic self-sufficiency, the family getting the backwash of the struggle. Girls have their primary struggle for independence in the family group; ultimately, they partly resolve this by becoming dependent on lovers and husbands. A girl seeks economic self-sufficiency, but she is likely to view this as transitional experience in her overall relationship to her world. (p. 18)

There are a number of other examples of Miller's attitudes plus a warning that if male and female parental roles become too coequal they are likely to produce sexually anxious or impotent men and angry women (p. 417). Miller does not consider the possibility that changing roles for women could lead to better adjusted children.

There are some miscellaneous criticisms as well. The chapter on psychological disturbances, which one might expect to be central to the book, is scanty. Miller expresses a few startling opinions here also.

> Only those adolescents who are brought up with religious teaching that masturbation is sinful, or by parents who were over-anxious about infantile sexuality, are likely to be anxious about this act. (p. 281)
>
> By puberty in Western culture it is inappropriate for children to share their parents' bed at any time. (p. 277)

What about prepubertal children?

There are also some notable inconsistences: the author deplores labels and artificial categories yet repeatedly dichotomizes adolescents into "academics" versus "non-academics"; he urges honesty yet suggests to parents that "it's better to be wrong with conviction than right with uncertainty" (p. 131) and lauds a rather glib and gimmicky psychotherapeutic stance in one instance (pp. 414ff.).

I would have liked more about various kinds of acting-out phenomena in adolescence, more on the Johnson-Szurek hypothesis, more on Anna Freud and Kenneth Keniston, and more on the concept of object removal. However, no book can cover every topic to every reader's satisfaction. This book comes close enough to being a compendium of adolescent psychology to prove useful to all readers.

HOWARD S. SUDAK, M.D.
Cleveland, Ohio

Clinical Sexuality: A Manual for the Physician and the Professions, *3rd ed., by John F. Oliven, M.D. Philadelphia, Pa., J.B. Lippincott Co., 1974, 530 pp., $24.00.*

This encyclopedic volume, now in its third edition, attempts to deal with the normal developmental aspects of the sexual function as well as with the pathological aspects. In spite of all the recent monumental revisions in our theoretical, practical, psychological, and physiological understandings of the sexual function in man, Oliven simply restates the old "formulas" without a critical selection of the valid versus the hangovers from tradition.

For example, some of the earlier notions of psychosexual development are presented without any real attempt to comprehend their significance in the light of more recent findings. Freud's notions about the oral, anal, and oedipal periods of psychosexual development are described as if they were validated facts about man rather than a useful theory that may be outmoded and no longer fruitful in its assertions and implications.

Oliven states, "At about 2½ years of age—sometimes much earlier, sometimes later—sensuous interest becomes gradually centered in the genitalia" (p. 14). What evidence is there that this is a sensuous interest? He goes on to say, "The child discovers these parts and explores them, and this is accompanied by vaguely pleasurable sensations" (p. 14). Oliven does not present any evidence to indicate how such pleasure differs from the pleasurable sensations in other exploratory activities of the child.

The portions of the book that deal with the early sexual activities of the child are particularly distressing because they involve important areas of sexual education but reassert the unconfirmed and questionable implications of the psychosexual theory. The author not only betrays his middle-class orientation in describing the effects of observing the sex act, but he seems to accept the negative consequences of witnessing the primal scene.

He describes a child observing the sexual act with "fascinated horror" and states,

> The child who chances on the parents in the act of sexual intercourse is frequently affected greatly and sometimes [in a] lastingly unfavorable manner. This impression of violence and aggression is carried to a point where the parents' moaning and groaning, postures and struggles are perceived as an act of brutal aggression and there are vivid images of choking, sticking, biting or eating the other, beating, even killing. (p. 39)

It is hard to believe that any enlightened author on sexuality could simply relate these outmoded and unvalidated notions about the child's view of sexual activity without at least raising the issue as to their validity. The idea that the sexual act connotes violence rather than tenderness is the heritage of our Victorian past and of early psychoanalytic notions about sexuality. These views continue to have wide influence because such volumes repeat them without any adequate validation.

Such descriptions lead to stern warnings about allowing parental intercourse to be observed or overheard rather than encouraging appropriate sexual privacy. Oliven states,

> Under no circumstances should there be exposure after age 2½ or 3. The incidence and the seriousness of psychic ill mount rapidly from this point on. (p. 41)

The same attitude is expressed in regard to nudity and the concern about "dissolute laxity or undue exposure of the parents." The body as a source of pride and positive regard is insufficiently emphasized in this point of view. However, some issues like sex play and masturbation are dealt with openly and with greater understanding.

When we come to the clinical portion of the book, however, Oliven's presentation of the normal as well as the abnormal, disordered, and deviant behavior is complete and authoritative. The book is well written and the index is extremely useful. For this reason, it certainly deserves a place in the library of most physicians.

LEON SALZMAN, M.D.
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Mental Handicap and Physical Environment: The Application of an Operational Philosophy to Planning, *by H.C. Gunzburg, M.A., Ph.D., and Anna L. Gunzburg. London, England, Bailliere Tindall (Baltimore, Md., Williams & Wilkins Co., exclusive U.S. agents), 1973, 247 pp., $14.00.*

During the last few years many psychiatrists in the United States have been developing a new interest in the care of the mentally retarded. I therefore think that this book is timely and of interest to many members of our profession. The authors show great interest in the education, handling, and care of the mentally retarded, but they do not direct themselves toward such issues as diagnosis or medical management and refer only tangentially to psychiatrists and other mental health professionals.

The book makes a strong plea for the idea that the progress of the mentally retarded is related primarily to the "individual orientation" of those who care for and educate these people rather than the "institutionally oriented" mental health professionals and other caretakers. It cites a number of quotations from the literature to indicate that progress for the mentally handicapped is not particularly related to the size of their place of residence, its per capita expenditures, or the age and pleasantness of facilities. However, it does admit that a "dismal, uninspired, barren physical environment" is undesirable due to its effect on the staff as well as on the patients.

The Gunzburgs point out that good progress, which includes increasing IQ and the development of social skills, is often quite spectacular when one small child is brought up, at least for a while, in an institution whose population is mainly older girls and women. The child gains a great deal of attention in this setting. On the other hand, it is emphasized that IQs and social skills tend to go down rather rapidly when there is a lack of individual attention, whether this occurs in an institution, a foster home, a hostel, or any other environment—including the patient's home.

The authors note that the effects of genetic endowment are limiting factors but that something can be done for almost everyone, although limitation of goals is necessary. They further emphasize that one key person should have as constant contact with the retarded child as conditions permit. One study they cite showed that slum children of retarded mothers were greatly helped by spending at least 20 hours a week in a research center where there were persons identified as "infant stimulators." These were women with limited training who worked with the children on a one-to-one basis.

The authors discuss the advantages as well as the disadvantages of institutional placement; they point out that such placement has much to offer patients from a "very bad home" but only a moderate amount to offer to those from "moderately bad homes."

It seems important that the patient have a place to put his own personal property. It is also emphasized that lack of stimulation, regardless of the reason, makes for a poorer prognosis. The patient should be allowed to make choices for himself insofar as he is competent to do so. The initiation of this policy usually has to be approached gradually with patients who have been institutionalized. They need to learn to make choices for themselves gradually rather than being overwhelmed by many demands to do so all at once.

Much of the book is devoted to architecture. As the authors explain, in the word "architect" they include not only professional architects but the administrators and mental health caretakers who advise them and decide what types of buildings to build.

The authors stress the advantages of mixed-sex wards; unfortunately, they have no suggestion on how to handle the sexual attraction that is bound to occur in some cases. In fact, from reading this book one would not realize that the mentally retarded have any sexual drive whatsoever.

There is also a long section on the defects of current architecture that points out the disadvantages of not only institutional settings but also of foster and private homes. This is followed by some suggestions for the types of architecture the authors feel are more satisfactory. They recognize that for economic reasons we will have to get along with the buildings that exist, but I think their ideas are useful and should be consulted by anyone who is involved in planning new facilities for the care of the mentally retarded.

A substantial portion of the recommendations they make in regard to architecture would be impractical in most parts of the United States, but these plans contain some ideas that could be adapted to the various climates and geographical features of this or any other country. There are also some useful suggestions for reshaping a hospital ward to make it more suitable for caring for the mentally retarded.

(I wish to acknowledge the help of Joseph Hillson, Ph.D., Chief Psychologist of the Norfolk Regional Center, in reviewing this book.)

WILLARD C. BRINEGAR, M.D.
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Obsessional States, *edited by H.R. Beech. London, Methuen & Co. (New York, N.Y., Barnes & Noble Books, Harper & Row, exclusive U.S. distributor), 1974, 342 pp., $17.00.*

The editor of this book has succeeded in bringing together the contributions of a group of authors into an evenly developed, very well-written, and comprehensive volume on the puzzling and troublesome psychiatric disorder of obsession.

The introduction defines the subjects to be discussed; a report on psychological studies of the obsessional personality and detailed case histories are also presented. Other chapters concern theories of the development of this psychic disturbance and criticism of these theories, various treatment modes and long- and short-term results, and therapeutic approaches. There is a 36-page list of references, an author index, and a subject index. The book is handsomely bound, and the typography is excellent.

I found the work to be a scholarly contribution to the literature and recommend it to students of psychiatry, students of psychiatric theory, psychologists, and practitioners of psychotherapy of all persuasions.

WILLIAM FLEESON, M.D.
Hartford, Conn.

Early Malnutrition and Mental Development. Symposia of the Swedish Nutrition Foundation XII, *edited by Joaquin Cravioto, M.D., Leif Hambraeus, M.D., and Bo Vahlquist, M.D. Stockholm, Sweden, Almqvist & Wiksell, 1974, 331 pp., 75 Swiss krona.*

This book is a collection of several papers from the Swedish Nutrition Foundation and the World Health Organization Workshop presented at a meeting in Sweden. The papers reflect the transition in research from relatively neat animal studies, in which the results of various nutritional deficiencies lead to relatively clear-cut deficiencies in mental and emotional functioning, to studies in human nutrition, which involve vast com-

plexities. For instance, vitamin B_6 deficiency in animals leads to a reduction in brain size, RNA synthesis, DNA synthesis, and nucleic acid synthesis. However, the specific role of vitamin B_6 in the mental development of man has yet to be clearly elucidated.

The problems encountered in this type of research in underdeveloped areas involve the complex interaction among malnutrition, untreated infectious diseases, and psychological factors due to disturbed family relationships. The clinical papers presented in this book often address themselves to the attempt to tease apart these various factors. This endeavor appears to be without success; detailed descriptions of nutritional interventions in field studies are often lacking.

Allusions are also made to the very real technical problems in supplemental nutrition programs. For instance, the government of Chile attempted a milk distribution program that would assure every child at least one pint of milk daily. Follow-up of this program over several years revealed that 25 percent of the distributed milk actually reached the hands of those for whom it was intended.

This book is of interest to workers in the field of nutrition and mental development. No one could doubt, either before or after reading this book, that adequate early nutrition is important for brain development. Although the book is of very limited interest to the average psychiatrist, it is certainly thought provoking.

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Life Stress and Illness, *edited by E.K. Eric Gunderson, Ph.D., and Richard H. Rahe, M.D. Springfield, Ill., Charles C Thomas, 1974, 254 pp., $19.50.*

This book is the result of a symposium on life stress and illness sponsored by the Science Committee of the North Atlantic Treaty Organization. The symposium was held at Beito, Norway, on June 12–16, 1972.

The conceptual model of psychosocial stress as it relates to disease is presented by Dr. Lennar Levi, Director of the Laboratory for Clinical Stress Research, Karolinska Institute, Stockholm. Dr. Levi recapitulates the concept of the nonspecificity of stress originally developed by Hans Selye (1). Dr. Levi identifies the concept as a working hypothesis to be tested in a number of situations. There is a brief review of some of the research done at the Karolinska Institute in terms of five objectives related to Selye's definition of stress.

The most interesting chapter in the book is W.T. Singleton's comment, which turns out to be a philosophical, methodological, and technical analysis of the concept of stress. Singleton concludes his essay with seven positive suggestions for the development of this field of research. In the following chapter, Aubrey Kagan examines strategies and technical problems related to further research in this field in the future. This paper highlights three of Singleton's recommendations: solve real problems, get into the field, and start large-scale prospective studies.

The rest of the book deals with some informative technical comments related to the standardization of life changes and scales measuring how recent certain events are. It also deals with life changes in relation to subsequent illness, e.g., myocardial infarction, coronary death, clinical depression, depressive and schizophrenic conditions, and biochemical and neuroendocrine response to severe psychological stress.

The material presented is interesting and well written. The empirical research presented is primarily retrospective in nature and reinforces Singleton's point regarding the need for well-structured large-scale prospective studies. The logical interrelatedness apparent in the introduction and in the first three chapters is less apparent in the rest of the book. However, on balance, *Life Stress and Illness* provides a fair indication of the status of the concepts and seems worth owning.

REFERENCE

1. Selye H: Stress and psychiatry. Am J Psychiatry 113:423–427, 1956

CLAUDEWELL S. THOMAS, M.D., M.P.H.
Newark, N.J.

Eidetic Parents Test and Analysis, *by Akhter Ahsen, Ph.D. New York, N.Y., Brandon House, 1972, 246 pp., $17.50.*

This book is by an author who is already well known for his work on the clinical behavior of eidetics. The book embodies a projective test-therapy technique that uses eidetic images for diagnosis and change of personality. An eidetic is different from a dream, daydream, guided fantasy image, or free association image in that it requires rigid fixation for arousal, and the perceptual quality of the image resembles near-hallucinatory vividness. Penfield (1) supplied neurological proof of such high-fidelity pictorial recordings, and Kubie (2) predicted a promising future for such images because they clearly circumvented ego defenses.

This book presents an artful technique for deep exposure to the eidetic images of parents. The technique enables patients to attack or circumvent resistances, undergo an experience deeper than conscious recall of memories concerning their parents, and develop spontaneous insights into family interactions and symbols. As consciously held views concerning the parents are corrected, perplexing sources of anxiety are explained. The meaning-building process released through eidetic visualization retrieves, reconstructs, and corrects consciousness.

Dr. Ahsen is an astute and creative therapist who presents the fundamentals of eidetic therapy in a very definitive and concise step-by-step manner. To my knowledge this is the only psychological or psychiatric work that bases its operations entirely on eidetics. Ahsen describes the basic unit of eidetic therapy as the ISM, a three-segment experience through the eidetic as an image (I), as a somatic feeling involving emotional and physiological states (S), and as meaning of a given experience (M). His emphasis on the eidetic experience as linked to both emotional and physiological states is bound to bring psychosomatics clearly into the field of psychiatry and might engender fruitful research projects.

Another of Ahsen's significant concepts is the consciousness-imagery gap (CIG). This is a valuable concept in uncovering discrepancies between a patient's perception and his conscious evaluation of it. Awareness of such discrepancies leads the patient and the therapist directly into the understanding of defenses against concepts and feelings. Repeated projection of eidetic images progressively clarifies emotional perspectives through surfacing of further experiential detail. Since the patient is more open in eidetic awareness, the therapist can transmit his knowledge to the patient in a much more definitive manner.

Although reading this book and applying its method involve some shifting of mental gears, especially in grasping the new concepts presented, the reader will be well rewarded by a remarkable preciseness in therapy. The amount of practical im-

agery that can be revealed through the method described is, in my opinion, unmatched in the clinical literature. The book represents a methodological advance; the experienced therapist will find joy in using it.

REFERENCES

1. Penfield W: Memory mechanisms. Arch Gen Psychiatry 67:178–191, 1952
2. Kubie LS: Discussion on papers by Drs Cobb and Penfield. Arch Gen Psychiatry 67:191–194, 1952

GREGORY SARMOUSAKIS, M.D.
Wilmington, Del.

Mental Retardation and Developmental Disabilities: An Annual Review, vol. VI, *edited by Joseph Wortis, M.D. New York, N.Y., Brunner/Mazel, 1974, 301 pp., no price listed.*

The volume is a scholarly, up-to-date compendium of research, programs, and developing trends in the field of mental handicaps. Medical, behavioral, and programmatic aspects of the volume are well balanced. It belongs on the bookshelf of anyone concerned with research in mental retardation and with planning for or helping the mentally handicapped.

This is the sixth in a series of annual reviews in mental retardation and developmental disabilities edited by Joseph Wortis. The series represents an ambitious undertaking in light of the vast scope of the areas covered. It should be evaluated in the context of the entire series because it is not possible or desirable to review and update every area every year. Some chapters, such as those dealing with hydrocephaly, represent definitive reviews of an entire area and appear for the first time. Others represent areas covered one or more times in previous volumes and are meant to bring the reader up-to-date.

Volume VI contains 12 major chapters and a short introduction by the editor. A chronicle of events in 1973 and a calendar for 1974 are also included. Similar chronicles and calendars have been presented in each of the preceding volumes.

Brief comments on each of the 12 chapters follow:

The chapter on clinical aspects by Kirman is geared primarily for the physician but is highly readable for nonmedical persons.

Anderson's chapter dealing with genetics and intelligence is a scholarly presentation.

Dignan and Warkany provide a major definitive review of hydrocephaly as a congenital malformation. They cover definition, incidence, etiology, course, anatomical and histological pathology, and treatment.

Himwich and Agrawal present a description of biochemical research that focuses on the relationship between abnormal brain biochemistry and mental retardation.

Braddock's contribution is unique in that it presents a study of federal funding policy using funds budgeted for specific federal programs as the criterion.

Farber's sociological survey covers "The Role in Society of Those Called Retarded."

Gallagher provides an interesting and provocative summary of recent educational trends, updating Gunzburg's previous review in this series.

Hall's survey of sexual behavior is a timely and very recent summary of an important area of concern for parents and administrators.

Hayden reviews evidence on performance, patterns of development, and the benefits of physical and recreational activities.

Posner's paper dealing with employment is anecdotal and experiential.

Schiefelbusch provides a scholarly updating of Spradlin's 1963 review of language behavior in mental retardation.

Dybwad traces the growth of the International League of Societies for the Handicapped in stimulating parent, volunteer, and national organizations.

GERALD R. CLARK, M.D.
Elwyn, Pa.

This Month's Reviewers

C.H. HARDIN BRANCH, M.D., is Program Chief, Santa Barbara County Mental Health Services, Santa Barbara, Calif., and Clinical Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif.

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JAMES W. DYKENS, M.D., is Director, Division of Mental Health, State of New Hampshire, Concord, N.H.

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GREGORY SARMOUSAKIS, M.D., is Senior Physician, Wilmington Medical Center, Wilmington, Del.

GERALD R. CLARK, M.D., is President, Elwyn Institute, Elwyn, Pa.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

Middle-Level Workers: Characteristics, Training and Utilization of Mental Health Associates. Community Mental Health Journal Monograph 8, *by E. Jo Baker, Ph.D., and Harold L. McPheeters, M.D. New York, N.Y., Behavioral Publications, 1975, 67 pp., no price listed (paper).*

Loving and Making Love: A Psychiatrist's Guide to Happiness and Pleasure, *by Dominick A. Barbara, M.D. Rockville, N.Y., Farnsworth Publishing Co., 1975, 169 pp., $8.95.*

The Residential Psychiatric Treatment of Children, *edited by Philip Barker, M.B., D.P.M., D.C.H. New York, N.Y., Halsted Press (John Wiley & Sons), 1974, 346 pp., $22.50.*

The Revolution in Psychiatry: The New Understanding of Man, *by Ernest Becker. New York, N.Y., Free Press (Macmillan Publishing Co.), 1974, 269 pp., $2.95 (paper).*

Early Child Care in Sweden. International Monograph Series on Early Child Care 2, *by Ragnar Berfenstam and Inger William-Olsson. New York, N.Y., Gordon and Breach, 1973, 155 pp., $9.50.*

Father Power, *by Henry Biller, Ph.D., and Dennis Meredith. New York, N.Y., David McKay Co., 1975, 368 pp., $9.95.*

Clonotherapy: A Manual for Convulsive Therapies, *by Lionel H. Blackman, M.D. Lake Worth, Fla., Lionel H. Blackman, 1974, 104 pp., no price listed (paper).*

Tests in Print II: An Index to Tests, Test Reviews, and the Literature on Specific Tests, *edited by Oscar Krisen Buros. Highland Park, N.J., Gryphon Press, 1974, 800 pp., $70.00.*

Information über Psychoanalyse: Therapeutische, theoretische und interdisziplinäre Askpekte, *edited by Günther Busch. Frankfurt, Germany, Suhrkamp Verlag, 1974, 180 pp., no price listed (paper).*

C.G. Jung and the Scientific Attitude, *by Edmund D. Cohen, Ph.D. New York, N.Y., Philosophical Library, 1975, 162 pp., $7.50.*

Pleneurethic: A New Approach to Life and Health, *by R.B. Collier. New York, N.Y., Vantage Press, 1974, 73 pp., $4.50.*

In Defense of Homo Sapiens, *by Joan Marble Cook. New York, N.Y., Farrar, Straus and Giroux, 1975, 215 pp., $8.95.*

Treatment Settings in Psychiatry: A Comparative Study, *by John B. Copas, B.Sc., Ph.D., Michael Fryer, B.Sc., and Ashley Robin, M.D., D.P.M. London, England, Henry Kimpton, 1974, 103 pp., £ 2.25 (paper).*

Behavior Modification in Rehabilitation Settings: Applied Principles, *edited by John G. Cull, Ph.D., and Richard E. Hardy, Ed.D. Springfield, Ill., Charles C Thomas, 1974, 245 pp., $12.50.*

La Psychiatrie de l'Enfant, *by Didier Duché. Paris, France, Presses Universitaires de France, 1974, 128 pp., no price listed.*

The Psychoanalytic Study of the Child, vol. 29, *edited by Ruth S. Eissler, Anna Freud, Marianne Kris, and Albert J. Solnit. New Haven, Conn., Yale University Press, 1974, 528 pp., $15.00.*

Body Consciousness, *by Seymour Fisher. New York, N.Y., Jason Aronson, 1974, 172 pp., $7.95.*

Behavioral Science in Management, *by Saul W. Gellerman. Baltimore, Md., Penguin Books, 1975, 133 pp., $2.25 (paper).*

Frame Analysis: An Essay on the Organization of Experience, *by Erving Goffman. Cambridge, Mass., Harvard University Press, 1974, 576 pp., $12.50.*

The Bethlehem Diaries: Student-Mental Patient Encounters, *by Stuart Golann, Jay M. Pomerantz, and Jeffrey Baker. San Francisco, Calif., Canfield Press (Harper & Row), 1974, 229 pp., $3.95 (paper).*

Psychoanalysis and Contemporary Science: An Annual of Integrative and Interdisciplinary Studies, vol. III, 1974, *edited by Leo Goldberger and Victor H. Rosen. New York, N.Y., International Universities Press, 1975, 544 pp., $15.00.*

Sexual Deviance and Sexual Deviants, *edited by Erich Goode and Richard R. Troiden. New York, N.Y., William Morrow & Co., 1974, 409 pp., $10.95.*

Sexual Identity Conflict in Children and Adults, *by Richard Green, M.D. Baltimore, Md., Penquin Books, 1975, 319 pp., $3.95 (paper).*

Career Guidance for Young Women: Considerations in Planning Professional Careers, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 203 pp., $13.75; $8.95 (paper).*

Teenage Nutrition and Physique, *by Ruth L. Huenemann, D.Sc., Mary C. Hampton, M.S., Albert R. Behnke, M.D.,*

Leona R. Shapiro, M.S., and Barbara W. Mitchell, M.S. Springfield, Ill., Charles C Thomas, 1974, 241 pp., $9.75.

Homicide: Investigative Techniques, *by Daniel J. Hughes, M.Ed. Springfield, Ill., Charles C Thomas, 1974, 350 pp., $16.75.*

Medical Nemesis: The Expropriation of Health, *by Ivan Illich. London, England, Calder & Boyars, 1975, 183 pp., £ 3.50; £ 1.25 (paper).*

The Myth of Meaning, *by Aniela Jaffé; translated by R.F.C. Hull. Baltimore, Md., Penguin Books, 1975, 186 pp., $2.25 (paper).*

Drug Use: Epidemiological and Sociological Approaches, *edited by Eric Josephson and Eleanor E. Carroll. Washington, D.C., Hemisphere Publishing Corp. (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 366 pp., $13.50.*

Living Your Dying, *by Stanley Keleman. New York, N.Y., Random House (Berkeley, Calif., Bookworks, copublisher), 1975, 160 pp., $6.95.*

Magic, Faith, and Healing: Studies in Primitive Psychiatry Today, *edited by Ari Kiev, M.D. New York, N.Y., Free Press (Macmillan Publishing Co.), 1974, 464 pp., $2.95 (paper).*

Somatic Manifestations of Depressive Disorders, *edited by Ari Kiev, M.D. New York, N.Y., Elsevier Publishing Co., 1974, 119 pp., $13.50 (paper).*

From Sad to Glad: Kline on Depression, *by Nathan S. Kline, M.D. New York, N.Y., G.P. Putnam's Sons, 1974, 252 pp., $7.95.*

Gesell and Amatruda's Developmental Diagnosis: The Evaluation and Management of Normal and Abnormal Neuropsychologic Development in Infancy and Early Childhood, *3rd ed., edited by Hilda Knobloch, M.D., and Benjamin Pasamanick, M.D. New York, N.Y., Harper & Row, 1974, 514 pp., $14.95.*

Biogenetic Structuralism, *by Charles D. Laughlin, Jr., and Eugene G. d'Aquili. New York, N.Y., Columbia University Press, 1974, 206 pp., $10.00.*

Youth, Socialization, and Mental Health. Mental Health Research in Asia and the Pacific, vol. III, *edited by William P. Lebra. Honolulu, Hawaii, University Press of Hawaii, 1974, 303 pp., $12.00.*

Handbook of Rorschach Scales, *edited by Paul M. Lerner. New York, N.Y., International Universities Press, 1975, 514 pp., $18.00.*

Rules for Raising Kids, *by Robert I. Lesowitz, M.D. Springfield, Ill., Charles C Thomas, 1974, 186 pp., $6.75 (paper).*

The Psychology of Sex Differences, *by Eleanor Emmons Maccoby and Carol Nagy Jacklin. Stanford, Calif., Stanford University Press, 1974, 627 pp., $18.95.*

Psychoanalytic Concepts of Depression, *2nd ed., by Myer Mendelson, M.D. Flushing, N.Y., Spectrum Publications (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 340 pp., $15.00.*

Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries, *by Joy Moser. Geneva, Switzerland, World Health Organization (Albany, N.Y., Q Corp., distributor), 1974, 106 pp., 20 Swiss francs (paper).*

Minutes of the Vienna Psychoanalytic Society, vol. IV: 1912–1918, *edited by Herman Nunberg and Ernst Federn. New York, N.Y., International Universities Press, 1975, 313 pp., $20.00.*

Normality: Theoretical and Clinical Concepts of Mental Health, *rev. ed., by Daniel Offer and Melvin Sabshin. New York, N.Y., Basic Books, 1974, 255 pp., $8.95.*

The Game of Wizards: Psyche, Science, and Symbol in the Occult, *by Charles Poncé. Baltimore, Md., Penguin Books, 1975, 240 pp., $2.50 (paper).*

Clinical Psychology: Issues of the Seventies, *edited by Albert I. Rabin. East Lansing, Mich., Michigan State University Press, 1975, 243 pp., $10.00.*

Just an Ordinary Patient: A Preliminary Survey of Opinions on Psychiatric Units in General Hospitals, *by Winifred Raphael, B.Sc. London, England, King Edward's Hospital Fund for London, 1974, 45 pp., £ 1.30 (paper).*

The Healing Alliance, *by Margaret Elmendorf Raymond, M.S.W., Andrew Edmund Slaby, M.D., M.P.H., and Julian Lieb, M.D. New York, N.Y., W.W. Norton & Co., 1975, 287 pp., $8.95.*

The Pornography Controversy: Changing Moral Standards in American Life, *by Ray C. Rist. New Brunswick, N.J., Transaction Books, 1975, 273 pp., $3.95 (paper).*

The Qualities of Mothering: Maternal Deprivation Reassessed, *by Michael Rutter, M.D. New York, N.Y., Jason Aronson, 1974, 155 pp., $7.50.*

Charisma: A Psychoanalytic Look at Mass Society, *by Irvine Schiffer. New York, N.Y., Free Press (Macmillan Publishing Co.), 1974, 184 pp., $3.95 (paper).*

Society and the Absurd, *by S. Giora Shoham. New York, N.Y., Springer Publishing Co., 1975, 198 pp., $9.50.*

Psychiatric Examination of Children, *2nd ed., by James E. Simmons, M.D. Philadelphia, Pa., Lea & Febiger, 1974, 233 pp., $6.00 (paper).*

The Re-entry Game, or "How's Your Sex Life—Now That You're Divorced?" *by Carole Sims. New York, N.Y., Warner Paperback Library, 1974, 223 pp., $1.25 (paper).*

Psychophysiological Studies of Emotion and Mental Disorders, *by Nozomi Suwa, M.D., and Itaru Yamashita, M.D. Tokyo, Japan, Igaku Shoin (Portland, Ore., International Scholarly Book Services, distributor), 1974, 226 pp., $12.50.*

New Approaches to College Student Development, *by Arthur L. Tollefson. New York, N.Y., Behavioral Publications, 1975, 144 pp., no price listed.*

Better Bowel Health, *by Marian T. Troy, M.B., B.S. New York,*

N.Y., Pyramid Books, 1974, 217 pp., $1.50 (paper).

Group Therapy 1974: An Overview, *edited by Lewis R. Wolberg and Marvin L. Aronson. New York, N.Y., Stratton Intercontinental Medical Book Corp., 1974, 221 pp., $14.75.*

Glossary of Mental Disorders and Guide to Their Classification, for Use in Conjunction with the International Classification of Diseases, 8th Revision, *by the World Health Organization. Geneva, Switzerland, WHO (Albany, N.Y., Q Corp., distributor), 1974, 77 pp., 12 Swiss francs (paper).*

Prompt Publication Policy

The *Journal* would like to remind authors who are particularly interested in early publication (whether to establish priority of an idea, reveal innovative results of new research, or for other pressing reasons) of its prompt publication policy. Under this policy, short (maximum of six double-spaced pages) manuscripts will be considered for publication in the Brief Communications section of the first available issue. These manuscripts must still undergo expert scrutiny before being accepted, and two months must be allowed for the printing process. However, the time required for publication of these short articles can be lessened considerably.

Authors who would like to have their manuscripts considered under this policy should indicate this desire, as well as the reasons for it, when they submit their manuscripts.

OFFICIAL ACTIONS

1975 Annual Meeting: Preliminary Program

Following is the preliminary program and other information related to the APA annual meeting, which will be held in Anaheim, Calif., May 5–9, 1975. The information here is what was available as of mid-January 1975; it is subject to additions, deletions, and other changes. Included are Registration and Related Information, the Scientific Program, and an Index of Participants. An official booklet containing additional information, such as the names of officers of sessions and of discussants, as well as locations, will be distributed in Anaheim at the time of registration.

Registration and Related Information

REGISTRATION

All registration will take place in North Exhibit Hall of the Anaheim Convention Center. The registration desk will be open:

Sunday, May 4—1:00 p.m. to 5:00 p.m.
Monday through Thursday, May 5–8—8:00 a.m. to 5:00 p.m.
Friday, May 9—8:00 a.m. to 12:00 noon.

A registration fee of $10 per day, or $40 for the five days, is required from all nonmembers with the exception of 1) invited nonmember program participants who are presenting papers or who are session officers, and their immediate families, 2) discussants, 3) participants on morning and evening panels and their immediate families, and 4) the immediate families of members of APA. Associate members, members-in-training, and their immediate families are also exempt from paying registration fees. The fee covers admission to the sessions and includes a badge and a copy of the official program. Badges are required for all sessions (including the opening session) and for the exhibit area. However, a badge does not cover admission to the business session of the Association, which is open only to members.

A $10 registration fee for the five days is required of visitors living outside the United States or Canada and of military personnel on active duty.

A $5 registration fee for the five days is required of the spouses and dependents of all nonmember registrants (excluding invited nonmember program participants).

A $5 registration fee for the five days is required of medical students, interns, residents, chaplains, nursing students, and students in the mental health professions and their spouses. Students must present a letter from their school or training facility instructor certifying their status.

The *Scientific Proceedings in Summary Form* for the 1975 annual meeting will be available throughout the week in the registration area of the Convention Center.

KEY LOCATIONS

All APA Staff offices will be located in the Convention Center.

Staff Offices	Orange 9, 10
Convention Office	Westminster 16
Journal Office	Costa Mesa 12
Press Offices	Fullerton 7, 8
Local Arrangements	Buena Park 15
Program Committee	Buena Park 14
Registration	North Exhibit Hall
Information and Message Center	Grand Lobby
Spouse Hospitality Center	Grand Lobby
First Aid	Kitchen First Aid

INFORMATION AND MESSAGE CENTER

This center will be located in the Grand Lobby and will be manned the same hours as registration.

Self-service message racks will be available for pick-up, deposit, and exchange of messages at all times, even when the message center is closed. Extremely urgent messages will receive the personal attention of APA staff members. All registrants are requested to check the message center periodically.

JOURNAL OFFICE

The office of *The American Journal of Psychiatry* will be in Costa Mesa 12. The office will be open from 9:00 a.m. to 5:00 p.m., Monday through Thursday, and on Friday until noon. Staff will be available to discuss any questions that authors who are presenting papers at the meeting may have. They particularly welcome the opportunity to confer with authors about tables and figures to be included in the papers.

Authors of numbered papers are reminded that all such papers are the property of the *Journal*. Permission must be secured from the Editor, Francis J. Braceland, M.D., before a paper may be considered for publication elsewhere. New research papers and papers presented at morning and evening panels do not automatically become the property of the *Journal*; however, authors may submit them for publication if they wish to do so.

It is the policy of the *Journal* to publish only original material that has not been published elsewhere in any form and that is not being considered for publication elsewhere. "Publication" includes recording on videotape or audiotape or appearance in printed form.

WRITERS' WORKSHOP

APA and the American Medical Writers Association will cosponsor a workshop on writing for scientific journals, to be held on Sunday, May 4, from 9:00 a.m. to 5:00 p.m. For further details see page 361.

PLACEMENT SERVICE

There will be a register available at the Membership Information Center for prospective employers and those seeking a new position.

PAPER NUMBERS

Paper numbers are assigned for your convenience in using this preliminary program; these numbers are subject to change. Final numbers will appear in the official APA program that will be distributed at the annual meeting.

MORNING AND EVENING PANELS

Morning panels will be held on Tuesday, Wednesday, and Thursday from 7:00 a.m. to 8:45 a.m. Breakfast may be obtained in regular hotel facilities. Evening panels will be held on Monday and Thursday at 8:00 p.m. All panels will be held at either the Disneyland Hotel, the Grand Hotel, the Sheraton Anaheim, or the Royal Inn. Check your official program for hotel listings for panels of interest.

CONTINUING EDUCATION COURSES

Continuing education courses on wide-screen closed-circuit color TV will be shown in the Arena, Convention Center, on Monday, 2:00 p.m.–5:30 p.m., Tuesday, 9:00 a.m.–12:15 p.m., Wednesday, 9:00 a.m.–12:00 noon and 2:00 p.m.–5:30 p.m., Thursday, 9:00 a.m.–12:00 noon and 2:00 p.m.–5:00 p.m., and Friday, 9:00 a.m.–12:00 noon.

FILMS

Films will be shown in the Anaheim Room, Convention Center, on Monday, 12:00 noon–5:00 p.m. and 8:00 p.m.–10:00 p.m., Tuesday, 9:00 a.m.–12:00 noon, Wednesday, 9:00 a.m.–5:00 p.m., Thursday, 9:00 a.m.–5:00 p.m. and 8:00 p.m.–11:00 p.m., and Friday, 9:00 a.m.–12:00 noon.

CONVOCATION

The convocation will take place Wednesday, May 7, at 7:30 p.m. in the Grand Ballroom, Disneyland Hotel.

FORUM ROOM

Rooms in the Anaheim Convention Center are available for the discussion of special issues during the course of the meeting. Any group that wishes to schedule a program must apply for use of a room by contacting the Program Committee Chairperson. Groups that have secured use of the rooms and that wish to have a placard prepared for display in the registration area should contact the Convention Manager in Westminster Room 16. Scheduled forums will be listed in the official program under APA Activities.

SPOUSE HOSPITALITY CENTER

The Local Arrangements Committee will have a Spouse Hospitality Lounge in the Grand Lobby of the Convention Center. Information on all leisure-time activities will be available Sunday through Thursday in this area. This area will also serve as the assembly point for all tours and special events.

PROFESSIONAL TOURS

Information on tours to facilities of psychiatric interest in the Anaheim area may be obtained from members of the Local Arrangements Committee in the Spouse Hospitality Center.

SHUTTLE BUS SERVICE

This service will be available between the Convention Center and nearby hotels. Route maps, hours of operation, and fare information are available at the Information and Message Center and in the registration area.

EXHIBITS

Technical and scientific exhibits will be on display in North Exhibit Hall, Convention Center, Monday through Wednesday, 8:00 a.m.–5:00 p.m.

An APA exhibit featuring services of the Association to its members will be located in North Exhibit Hall, Convention Center, Monday through Wednesday.

FAMILY FUN AT DISNEYLAND

This will take the place of the Annual Banquet. Disneyland Park will be reserved for the exclusive use of the APA membership from 7:00 a.m. to midnight on Tuesday, May 6. Tickets may be purchased in the registration area.

SPECIAL BRUNCH

A brunch and fashion show will be held in honor of the families of APA officers on Wednesday, May 7, at 11:00 a.m. at the Balboa Bay Club. Tickets for the brunch and fashion show are $15 per person and may be purchased in the registration area. Buses will depart at 10:30 a.m. from the Grand Lobby.

SPECIAL LECTURE BY DR. BERTRAM S. BROWN

As this issue was going to press, word was received of the addition of a special lecture on "The Life of Psychiatry" by Bertram S. Brown, M.D., Director, National Institute of Mental Health, on Monday at 2:00 p.m. The lecture will be Session IX, and "Continuing Education" will become Session X.

MONDAY, MAY 5 9:00 A.M.

Official Opening of the 128th Annual Meeting of the American Psychiatric Association

Call to Order: *John P. Spiegel, M.D. (F),[1] President*

Selections by the University Singers of California, Fullerton: *David Thorsen, Conductor*

Official Greetings: *The Honorable Ralph A. Diedrick, Chairman of the Orange County Board of Supervisors, The Honorable William J. Thom, Mayor of Anaheim*

Introduction of Visiting Dignitaries

Introduction of Chairpersons of the Program and Arrangements Committees: *H. Keith H. Brodie, M.D. (F), Paul V. Gustafson, M.D. (M)*

1 Presidential Address: *John P. Spiegel, M.D. (F)*

Response of the President-Elect: *Judd Marmor, M.D. (LF)*

Organist: *John E. Fryer, M.D. (M)*

Reception

MONDAY, MAY 5 12:00 NOON

Films I: Noon Feature: Families Under Stress*

F1 The Green Wall

*This session continues until 1:50 p.m.

MONDAY, MAY 5 2:00 P.M.

Session I: Disaster at Buffalo Creek: Studies of 160 Families *(Joint Session with the American Psychoanalytic Association)*

2 From Chaos to Responsibility
Gerald M. Stern, LL.B. (I)

3 Loss of Communality at Buffalo Creek
Kai Erikson, Ph.D. (I)

4 The Human Meaning of Total Disaster
Robert J. Lifton, M.D. (F), Eric Olson, M.A. (I)

5 Children of Disaster
C. Janet Newman, M.D. (F)

6 Family and Character Change in Buffalo Creek
James L. Titchener, M.D. (F), Frederic T. Kapp, M.D. (F)

[1]The following abbreviations refer to membership in the American Psychiatric Association:

(A) Associate
(CF) Corresponding Fellow
(DF) Distinguished Fellow
(F) Fellow
(HF) Honorary Fellow
(LF) Life Fellow
(M) Member
(MT) Member-in-Training
(DM) Distinguished Member
(LM) Life Member
(I) Invited Participant

Session II: Biofeedback and Self-Control

7 Biofeedback: A Clinician's Perspective
Stephen C. Padnes, M.D. (M)

8 Biofeedback, Self-Regulation, and Stress Disorders
Johann Stoyva, Ph.D. (I)

9 EEG Biofeedback: Research and Clinical Problems
Maurice B. Sterman, Ph.D. (I)

10 Theta EEG Feedback: A New Psychotherapeutic Tool
Elmer E. Green, Ph.D. (I)

11 Applied Biofeedback: A Systems Approach
Thomas H. Budzynski, Ph.D. (I)

Session III: Current Concepts of Schizophrenia

12 Diagnosis
William T. Carpenter, Jr., M.D. (M)

13 The Family
David Reiss, M.D. (M)

14 Social and Environmental Interaction
Melvin Kohn, Ph.D. (I)

15 Genetics
Stephen Mattysee, Ph.D. (I)

16 The Psychotomimetic Model
J. Christian Gillin, M.D. (M)

17 Serum and Blood Factors
Herbert Meltzer, M.D. (M)

18 The Dopamine Hypothesis
Solomon H. Snyder, M.D. (F)

19 Treatment
John M. Davis, M.D. (F)

Session IV: Follow-Up Studies of Community Care

20 Follow-Up Evaluation of an Inpatient Alternative Program
Paul R. Polak, M.D. (A), Mick Kirby, Ph.D. (I)

21 Training in Community Living: One Year Evaluation
Leonard I. Stein, M.D. (F), Mary Ann Test, Ph.D. (I)

22 Symptom Stability Among Patients After Discharge
Steven Gurgevick, Ph.D. (I), Allan Beigel, M.D. (M), Frank A. Petroni, Ph.D. (I)

23 Follow-Up Study of Berkeley House: A Psychiatric Halfway House
Richard D. Budson, M.D. (M), Mollie C. Grob, S.M. (I)

23a Soteria: One- and Two-Year Follow-Up
Loren R. Mosher, M.D. (M)

Session V: Special Lecture

24 Clinical Significance of Research on Coping and Adaptation
David A. Hamburg, M.D. (F)

Session VI: Family I

25 Brief Versus Standard Hospitalization: The Families
Marvin I. Herz, M.D. (F), Jean Endicott, Ph.D. (I), Robert L. Spitzer, M.D. (F)

26 Family Therapy in Aftercare: A Unique Approach
Paul E. Wood, M.D. (M)

27 A Psychosocial Kinship Model for Family Therapy
E. Mansell Pattison, M.D. (F), Don De Francisco, M.D. (MT), Paul E. Wood, M.D. (M), Hal Frazier, M.D. (MT)

28 Family Studies and Psychoanalytic Theory and Therapy
Theodore Lidz, M.D. (LF)

29 Current Trends in the Training of Family Therapists
Edward W. Beal, M.D. (M)

30 Psychiatric Dimensions of Family Practice
Sidney Werkman, M.D. (F), Linda Mallory (I), Jeffrey Harris (I)

31 Treatment for the Parents of Feminine Boys
Lawrence E. Newman, M.D. (M)

Session VII: Drugs of Abuse

32 EEG Sleep Patterns and Drug Abuse
Ismet Karacan, M.D. (F), Robert L. Williams, M.D. (F), Betsy S. Comstock, M.D. (M), Eric G. Comstock, M.D. (I), Masako Okawa, M.D. (I)

33 *l*-α-Acetylmethadol Prognostic Considerations
Richard B. Resnick, M.D. (M), Lois Orlin, M.S.W. (I), Gretchen Geyer (I), Alfred M. Freedman, M.D. (F)

34 An Epidemic of Drug-Induced Schizophrenia
Paul V. Luisada, M.D. (M), Catherine Reddick, R.N. (I)

35 Treatment Related Factors in Alcoholic Populations
Melvin L. Selzer, M.D. (F), Louis van Rooijen, Ph.D. (I)

36 Behavior Therapy and Alcohol Abuse in Adolescents
Joseph D. Teicher, M.D. (LF), Ruth D. Sinay, Ph.D. (I), Jerome S. Stumphauzer, Ph.D. (I)

37 In-Hospital Treatment of Alcoholic Couples
Peter Steinglass, M.D. (M), Donald I. Davis, M.D. (M), David Berenson, M.D. (I)

Session VIII: Delivery of Mental Health Services to Minority Groups

38 Service Delivery in the Black Community
Hiawatha Harris, M.D. (F)

39 The Use and Misuse of the Indian Paraprofessional
Humphrey C. Townsley, M.D. (M)

40 The Internal Administration of a CMHC
Lindbergh S. Sata, M.D. (M)

41 Service Delivery in the Spanish-Speaking Community
Angel Gregorio Gomez, M.D. (M)

42 New Legislation in Mental Health
Frank Ochberg, M.D. (M)

43 National Institute on Alcohol Abuse and Alcoholism in Minority Programs
John Wolfe, Ph.D. (I)

44 National Institute on Drug Abuse in Minority Programs
Lee Dogoloff (I)

Session X:* Continuing Education *(Videotape Special Session)*

2:00 Exploring Nonverbal Communications in Couples: Freeze-Frame Video
Presented by: Ian Alger, M.D. (F)

2:45 Social Interaction in Homes of Alcoholics
Presented by: Alfonso Paredes, M.D. (F); Dick Gregory (I) (Discussant)

3:45 Lesbian Mothers and Their Children
Presented by: Martha Kirkpatrick, M.D. (F); Katherine V.R. Smith (I), Del Martin (I) (Discussants)

*Session IX: see bottom of p. 322 for new information on special lecture by Bertram S. Brown, M.D.

Films II: Women's Health Issues *(Joint Session with the Task Force on Women in Psychiatry)**

F2 Menstruation

F3 Period Piece

F4 Taking Our Bodies Back

F5 Image and Reality

*This session continues until 5:00 p.m.

MONDAY, MAY 5 8:00 P.M.

Films III: Special Film Seminar*

F6 The Psychiatrist in Film

*This session continues until 10:00 p.m.

Evening Panels

A APA Task Force on Women in Psychiatry
Moderator: Elissa P. Benedek, M.D. (F)
Panelists: Anne M. Seiden, M.D. (M), Carol S. Wolman, M.D. (M), Martha Kirkpatrick, M.D. (F), Mary Ann Bartusis, M.D. (F), Nancy A. Durant, M.D. (F)

B Group Approaches to Sex Education in Inner City Adolescents
Moderator: Pedro Ruiz, M.D. (M)
Panelists: Saul Scheidlinger, Ph.D. (I), Jose R. Lombillo, M.D. (M), Ruth Hochberg, Ph.D. (I), Melvin Roman, Ph.D. (I), Travis Simon, M.D. (I)

C Psychodrama I
Moderator: Neville Murray, M.D. (F)
Panelist: Zerka T. Moreno (I)

D Problems of and for the Law Enforcement Officer
Moderator: Frederic T. Kapp, M.D. (F)
Panelists: Earl J. Simburg, M.D. (LF), Floyd O. Due, M.D. (F), Donald Rossi, Ph.D. (I), Jesse Rubin, M.D. (F), Robert J. Sokol, M.D. (F)

E Future Developments on the Frontiers of Psychiatry
Moderator: John S. Lawall, M.D. (MT)
Panelists: Judd Marmor, M.D. (LF), Robert O. Pasnau, M.D. (F), Stanley L. Portnow, M.D. (F), Arnold Mandell, M.D. (F), Elliott Heiman, M.D. (M)

F Hearing or Seeing: What Is Best in Nonpsychiatric Physicians' Education?
Moderator: Alexander N. Levay, M.D. (F)
Panelists: Lawrence Sharpe, M.D. (I), John Romano, M.D. (LF), Thomas Webster, M.D. (F), Lucy Zabarenko, Ph.D. (I), Robert Daugherty, M.D. (I)

G Demonstration of Encounter Techniques
Moderator: William Earl Moore, M.D. (LM)
Panelists: Nicholas Fish, M.D. (F), Timothy M. Magee, M.D. (F)

H Generative Graphics: Image Making in Psychotherapy
Moderator: Marvin Karno, M.D. (F)
Panelists: Barnett Addis, Ph.D. (I), Joseph Brunon, M. Arch. (I), Sheldon Kardener, M.D. (M), Joseph Sicignano, M.D. (MT)

I Psychiatry and Current "Psychic" Research
Moderator: Stanley R. Dean, M.D. (F)
Panelists: Paul L. Adams, M.D. (F), Eugene B. Brody, M.D. (F), Mohammed Shafie, M.D. (A), Elmer E. Green, Ph.D., (I), Alyce M. Green (I)

J Roots of Gender—Chauvinism Within the Family
Moderator: Natalie Shainess, M.D. (F)
Panelists: Sherwyn M. Woods, M.D. (F), Robert E. Gould, M.D. (F), Anita T. Bell, M.D. (F), Robert Seidenberg, M.D. (F)

K The Revolving Door
Moderator: Eugene B. Feigelson, M.D. (F)
Panelists: Alvin M. Mesnikoff, M.D. (F), Edwin S. Robbins, M.D. (F), Jack Sheps, M.D. (F), John A. Talbott, M.D. (F)

L Mental Health Economics: The Case for NHI Benefits
Moderator: Henry A. Foley, Ph.D. (I)
Panelists: Steven Sharfstein, M.D. (M), David Berenson, M.D. (I)

M The Stress of Parenting
Moderator: Arnold L. Gilberg, M.D. (F)
Panelists: Saul Brown, M.D. (F), Myrtle LeBow, M.D. (M), Alexander Rogawski, M.D. (F)

N Increasing Child Teaching in the General Residency
Moderator: Wells Goodrich, M.D. (F)
Panelists: Justin Call, M.D. (F), Alexander Z. Guiora, Ph.D. (I)

O Family Therapy by Male-Female Cotherapy Teams
Moderator: Lawrence W. Lazarus, M.D. (M)
Panelists: Kurt Schlesinger, M.D. (M), Stephen S. Leavitt, M.D. (M), Andrea H. Lazarus, M.S. (I), Maribelle Leavitt, R.N. (I), Barbara Artson, M.A. (I)

P The Viet Nam Veteran: Continuing Problems of Readjustment
Moderator: Leonard Neff, M.D. (F)
Panelists: Jonathan Borus, M.D. (M), Peter Bourne, M.D. (M), Robert J. Lifton, M.D. (F), Lee Robbins, Ph.D. (I), Chaim Shatan, M.D. (M), George Solomon, M.D. (F)

Q Confidentiality in the Public Mental Health Sector
Moderator: Roger Peele, M.D. (F)
Panelists: Horace Greene, M.D. (M), Jefferson McAlpine, M.D. (M), John H.L. Marshall, M.D. (M), Julie Ponquinette, M.D. (I), Irving Schneider, M.D. (F)

R Psychiatric Health Services and Metropolitan Jails
Moderator: John Petrick, M.D. (M)
Panelists: Donald Verin, M.D. (I), Harold C. Deering, M.D. (M), Anthony Elite, M.D. (I), Raymond Anderson, Ph.D. (I)

S Depression in the Heroin Patient: Myth or Reality?
Moderator: Jacob Schut, M.D. (M)
Panelists: Aaron T. Beck, M.D. (M), Jonathan O. Cole, M.D. (F), Edward C. Senay, M.D. (F), Charles O'Brien, M.D. (M)

T Residents Compare Unified and Block Training
Moderator: John S. Strauss, M.D. (M)
Panelists: Bruce Granovetter, M.D. (I), Simeon Grater, M.D. (MT), Tom Segall, M.D. (I), Kent Hart, M.D. (MT)

U Current Modalities of Sexual Therapies
Moderator: Arthur Zitrin, M.D. (F)
Panelists: Stanley Coen, M.D. (M), Bluma Swerdloff, Ph.D. (I), John F. O'Connor, M.D. (F), Virginia Lozzi, M.D. (M), Harry Albert, M.D. (M), Lothar Gidro-Frank, M.D. (F)

V Love, Sexual Dysfunctions, and the Sexual Revolution
Moderator: Samuel V. Dunkell, M.D. (A)
Panelists: George Serban, M.D. (M), Laurice W. Glover, M.S.S.W. (I)

W Team Training in Community Mental Health
Moderator: Lt. Col. James H. Rumbaugh, MC (A)
Panelists: Lt. Col. John N. Follansbee, MC (M), Maj. Richard G. Newhouse, MC (I), Capt. Paul Rumbaugh, MSC (I), 1st Lt. Paul Clavelle, MSC (I)

X Ethnic Variation: A Problem in Psychiatric Training
Moderator: Carl Eisdorfer, Ph.D., M.D. (F)
Panelists: E.H. Auerswald, M.D. (A), Robert Kraus, M.D. (F), Lindbergh S. Sata, M.D. (M), James H. Shore, M.D. (M), William M. Womack, M.D. (F)

Y Impact of Judicial Decisions on Mental Health Care
Moderator: Louis E. Kopolow, M.D. (M)
Panelists: Alan A. Stone, M.D. (F), Charles R. Treadway, M.D. (F), Seymour Pollack, M.D. (F), Herb Silverberg (I)

Z PSRO and the Problem-Oriented Record
Moderator: Ralph S. Ryback, M.D. (M)
Panelists: Robert Fowler, M.D. (M), Richard Longabaugh, Ed.D. (I), Richard Dorsey, M.D. (M)

Z1 Human Services to Spanish-Speaking Migrant Workers

Moderator: Angel Gregorio Gomez, M.D. (M)
Panelists: Rodolfo Sanchez (I), Rodolfo Alvarez, Ph.D. (I)

Z2 Dialogue on Alcoholism
Moderator: John A. Ewing, M.D. (F)
Panelists: Keith S. Ditman, M.D. (F), Ebbe C. Hoff, M.D. (A), Jack H. Mendelson, M.D. (F), Robert A. Moore, M.D. (F), E. Mansell Pattison, M.D. (F)

Z3 Drug Abuse: The Unremitting Epidemic
Moderator: Jordan Scher, M.D. (M)
Panelists: Peter Bourne, M.D. (M), Robert Newman, M.D. (I)

Z4 Current Concepts of Schizophrenia*
Moderator: Richard Jed Wyatt, M.D. (M)
Panelists: William T. Carpenter, Jr., M.D. (M), David Reiss, M.D. (M), Melvin Kohn, Ph.D. (I), Stephen Mattysee, Ph.D. (I), J. Christian Gillin, M.D. (M), Herbert Meltzer, M.D. (M), Solomon H. Snyder, M.D. (F), John M. Davis, M.D. (F)

*Continuation of Monday afternoon Session III.

TUESDAY, MAY 6 7:00 A.M.

Morning Panels

Tu1 Reports from Local Groups of Women Psychiatrists
Moderator: Carol S. Wolman, M.D. (M)
Panelists: Barbara E. O'Connell, M.D. (M), Ann Laycock Chappell, M.D. (M), Ursula Henderson, M.D. (M), Carol Nadelson, M.D. (F), Elaine Hilberman, M.D. (M)

Tu2 Cubans in the U.S.A.: A Mental Health Profile
Moderator: James N. Sussex, M.D. (F)
Panelists: Pedro Ruiz, M.D. (M), David Pinosky, M.D. (A), Fernando Milanes, Jr., M.D. (M), Luis P. Garrigo, M.D. (M), Esteban Valdes-Castillo, M.D. (M)

Tu3 Psychodrama II
Moderator: Neville Murray, M.D. (F)
Panelists: Zerka Moreno (I), Ernest Fantel, M.D. (F)

Tu4 Psychodynamics of Administration
Moderator: David W. Kennard, M.D., Ph.D. (M)
Panelists: Frederick Redlich, M.D. (LF), Gerald L. Klerman, M.D. (F), Louis B. Fierman, M.D. (F), Herbert Shepherd, M.D. (I), Leonard B. Belcore, M.B.A. (I), Milton S. Greenblatt, M.D. (F)

Tu5 On the Emotional Well-Being of Psychiatrists
Moderator: Elaine J. Knutsen, M.D. (F)
Panelists: Gordon E. Bermak, M.D. (F), Herbert McGrew, M.D. (A), Lewis McKeever, M.D. (F), David H. Rosen, M.D. (MT), Frederick R. Ford, M.D. (F)

Tu6 Follow-Up Studies on Battered Children
Moderator: John B. Reinhart, M.D. (F)
Panelists: Elizabeth Elmer, M.S.W. (I), F. Gordon Foster, M.D. (I), Ruth Kempe, M.D. (M), Richard Martin, M.D. (I)

Tu7 Women's Studies in Psychiatric Education II
Moderator: Anne M. Seiden, M.D. (M)
Panelists: Malkah Notman, M.D. (M), Leon Salzman, M.D. (F), Martha Kirkpatrick, M.D. (F), Jean Baker Miller, M.D. (M)

Tu8 Psychoanalytic Training and Psychiatric Practice
Moderator: G. Pirooz Sholevar, M.D. (F)
Panelists: Barbara G. Deutsch, M.D. (A), Stanley Stern, M.D. (M), Charles Stone, M.D. (F), Linn A. Campbell, M.D. (M), Calvin Colarusso, M.D. (M)

Tu9 Family-Focused Medical and Psychiatric Care
Moderator: Stephen Fleck, M.D. (F)
Panelists: George Brunell, M.D. (I), Salvador Minuchin, M.D. (I), Nathan Epstein, M.D. (F), John Donnelly, M.D. (F)

Tu10 Key Issues in Polydrug Abuse
Moderator: Edward Kaufman, M.D. (M)
Panelists: John Benvenuto, M.D. (I), Peter Bourne, M.D. (M), John N. Chappel, M.D. (M), Betsy Comstock, M.D. (M), David Smith, M.D. (I)

Tu11 Resident Training in Family Therapy—Who Can Teach?
Moderator: Thomas P. Detre, M.D. (F)
Panelists: Gordon Fuqua, M.D. (I), Froma Walsh, M.S.W. (I), Raymond Zablotney, M.D. (I), Christopher Erstling, M.D. (I), Carol M. Anderson, M.S.W. (I)

Tu12 Art Therapy
Moderator: Paul Jay Fink, M.D. (F)
Panelists: Elliot R. Reiner, M.D. (F), Helen Landgarten, A.T.R. (I), Paul Fox, M.D. (I), Phyllis Miller (I)

Tu13 Future of the Private Practice of Psychiatry
Moderator: Arnold L. Gilberg, M.D. (F)
Panelists: Donald Naftulin, M.D. (F), Robert Nemiroff, M.D. (M), Jona Perlmutter, M.D. (M)

Tu14 Prison Psychiatry: Good or Bad for Prisoners?
Moderator: Melvin S. Heller, M.D. (F)
Panelists: Robert L. Sadoff, M.D. (F), Jonas Rappaport, M.D. (F), Louis B. Aytch (I), Edward B. Guy, M.D. (M), Arthur Boxer, M.D. (M)

Tu15 The New Sex Therapy and Psychiatric Office Practice
Moderator: Alexander N. Levay, M.D. (F)
Panelists: Harold I. Lief, M.D. (F), John B. Reckless, M.D. (F), Maj-Britt Rosenbaum, M.D. (M), Phillip E. Veenhuis, M.D. (M)

Tu16 The Private Practice of Community Psychiatry
Moderator: Allan Levy, M.D. (F)
Panelists: Norman Graff, M.D. (F), Howard Gurevitz, M.D. (F), Thomas Samuels, M.D. (I), Donald Newman, M.D. (F), Warren Vaughan, Jr., M.D. (F)

Tu17 Fantasy, Creativity, and Poetry Therapy
Moderator: Anthony Pietropinto, M.D. (M)
Panelists: John Antel, M.D. (F), Morris R. Morrison, M.A. (I), Joy Shieman (I)

Tu18 Psychotherapy with Homosexuals
Moderator: Richard C. Pillard, M.D. (F)
Panelists: Jean Munzer, M.D., Ph.D. (M), Pam Oline (I), Mark Freedman, Ph.D. (I), Bill Horstman, Ph.D. (I), Betty Berzon, M.S. (I)

Tu19 Outreach in the Community: Invitation or Intrusion?
Moderator: George S. Sigel, M.D. (M)
Panelists: Peter B. Randolph, M.D. (I), William G. Kantar, M.D. (A), Stephen B. Bernstein, M.D. (A), Joanna Donovan, M.S. (I)

Tu20 Multi-State Information System: Results, Plans, and How to Use It
Moderator: Zebulon Taintor, M.D. (F)
Panelists: Eugene Laska, Ph.D. (I), Carole Siegel, Ph.D. (I)

Tu21 New Mental Health Teams
Moderator: John Chapman Urbaitis, M.D. (M)
Panelists: Mary Jane Lucas, R.N. (I), Roger C. Sider, M.D. (MT), Thomas N. Wise, M.D. (M), Gail Wise, M.S.W. (I)

Tu22 Recent Research in Schizophrenia: Special Report 1975
Moderator: Loren R. Mosher, M.D. (F)
Panelists: Samuel J. Keith, M.D. (I), Herbert Meltzer, M.D. (A), Leopold Bellak, M.D. (F), Norman Garmezy, Ph.D. (I), John G. Gunderson, M.D. (M)

Tu23 Factors Influencing Drug Treatment in Depression
Moderator: Barry Blackwell, M.D. (M)
Panelists: Heinz E. Lehmann, M.D. (F), Carl Eisdorfer, M.D. (F), Alexander H. Glassman, M.D. (F)

Tu24 The Teaching of Emergency Psychiatry
Moderator: Stephen G. Landau, M.D. (M)
Panelists: Thomas N. Rusk, M.D. (A), Noel Hoell, M.D. (A), John S. Strauss, M.D. (M), Mark Rhine, M.D. (M), Abraham Twerski, M.D. (I)

Tu25 Rehabilitation: State, National, International Perspectives
Moderator: Nathan Kline, M.D. (F)
Panelists: Bertram S. Brown, M.D. (F), Thomas Adeoye Lambo, M.D. (I)

TUESDAY, MAY 6 10:00 A.M.

Solomon Carter Fuller Lecture

45 The Interface of Mental Health and Education
Wilson Riles, Ph.D., Superintendent of Public Instruction and Director of Education, Department of Education, State of California, Sacramento, Calif.

TUESDAY, MAY 6 9:00 A.M.

Session I: Psychopathology

46 A Computer-Assisted Psychiatric Assessment Unit
Thomas A. Williams, M.D. (M), James H. Johnson, Ph.D. (I), Eugene L. Bliss, M.D. (F)

47 Clinical Criteria for Psychiatric Diagnosis
Robert L. Spitzer, M.D. (F), Jean Endicott, Ph.D. (I), Eli Robins, M.D. (F)

48 Twin Studies of Affective Illness
Martin G. Allen, M.D. (M)

49 Studies in Postpsychotic Depression
Thomas H. McGlashan, M.D. (M), William T. Carpenter, Jr., M.D. (M)

50 Agitated Depression and Mania: a Rare Syndrome
Jonathan M. Himmelhoch, M.D. (I), David J. Kupfer, M.D. (F), Patricia Coble, R.N. (I), Thomas P. Detre, M.D. (F)

51 Are Personality Disorders Diseases?
Richard A. Schwartz, M.D. (M), Ilze K. Schwartz, M.D. (M)

52 Prognostic Correlates of Psychotherapy
Arthur K. Shapiro, M.D. (F), Elmer L. Struening, Ph.D. (I), Elaine Shapiro, Ph.D. (I), Harvey Barten, M.D. (F), Ann Rosen, M.A. (I)

Session II: Sex Therapy

53 New Developments in Sex Therapy
William H. Masters, M.D. (I), Virginia Johnson Masters (I)

54 Psychoanalysis and the Sex Therapies
Robert Michels, M.D. (F)

55 Sex Therapy and Behavior Therapy
John Paul Brady, M.D. (F)

56 Sex Therapy and Marital Therapy
Clifford J. Sager, M.D. (F)

Session III: Sleep Disorders

57 Differential Diagnosis of Sleep Complaints
William C. Dement, M.D. (M)

58 The Effect of REM Sleep Reduction on Depression
Gerald W. Vogel, M.D. (M)

59 Therapeutic Considerations in Treating Insomnia
Anthony Kales, M.D. (M)

60 Sleep and Neuroendocrine Patterns in Man
Elliot D. Weitzman, M.D. (I)

61 Is There a Sleep Disorder of Schizophrenia?
J. Christian Gillin, M.D. (M)

62 Narcolepsy and the Hypersomnias
Jerome V. Holland, M.D. (F)

Session IV: Peer Review

63 Can Psychiatry Police Itself Effectively?
Henriette R. Klein, M.D. (LF), Arthur Zitrin, M.D. (F)

64 Medical Records: Treatment Boon or Payment Hazard
Lucy D. Ozarin, M.D. (LF), Abe S. Abraham, M.D. (M)

65 Peer Review of Prescribing Patterns in a CMHC
Herbert Diamond, M.D. (M), Richard Tislow, M.D. (M), Thoburn Snyder, M.D. (I), Karl Rickels, M.D. (F)

66 Peer Review Effects on Patterns of Psychotherapy
Lorraine L. Luft, M.C.P. (I), Donald E. Newman, M.D. (F), Pamela A. McMickin, M.A. (I)

67 Peer Review in Illinois: Four Years' Experience
Alex J. Spadoni, M.D. (F)

68 Peer Review: Therapist and Patient Follow-Up Survey
Lawrence M. Sampson, M.D. (M), Lorraine L. Luft, M.C.P. (I), Donald E. Newman, M.D. (F), Vard Kazangian, Ph.D. (I)

Session V: Special Lecture

69 Psychological Sex Differentiation in Childhood
Eleanor Maccoby, Ph.D.

Session VI: Family II

70 Mental Illness and the Family in America and India
Jagdish S. Teja, M.D. (M)

71 The Family in Exile: Cuban Expatriates in the U.S.A.
Ruben Dario Rumbaut, M.D. (M), Gustavo Rumbaut, M.A. (I)

72 Psychiatric Effects of Asian Captivity
Richard C.W. Hall, M.D. (M), Patrick T. Malone, M.D. (I)

73 Lithium Prophylaxis: The Married Couples Group
Yolande B. Davenport, M.S.W. (I), Michael H. Ebert, M.D. (I), Marvin L. Adland, M.D. (F), Frederick K. Goodwin, M.D. (M)

74 A New Finding and Concept in Morbid Jealousy
John P. Docherty, M.D. (M), Jean Ellis, R.N. (I)

75 The "Wonderful" World of Disney
Michael Brody, M.D. (M)

76 The Effects of the Sealed Record in Adoption
Arthur D. Sorosky, M.D. (M), Annette Baran, M.S.W. (I), Reuben Pannor, M.S.W. (I)

Session VII: The Social Intoxicants: Alcohol and Marijuana

77 Alcohol and Marijuana: Comparative Psychopharmacology
Jack H. Mendelson, M.D. (F), Nancy K. Mello, Ph.D. (I)

78 Marijuana and Hostility in a Small Group Setting
Carl Salzman, M.D. (M), Bessel A. van der Kolk, M.D. (M), Richard I. Shader, M.D. (F)

79 Marijuana, Alcohol, and Interpersonal Perceptions
Frederick T. Melges, M.D. (M)

80 Experiencing and Altering States of Intoxication
Herbert Weingartner, Ph.D. (I), Richard C. Stillman, M.D. (A)

81 The Intoxication "State of Consciousness"
Marc Galanter, M.D. (M)

Session VIII: Advances in Psychoanalytic Psychology of Children *(Joint Session with the Academy of Psychoanalysis)*

82 Observational Studies of Child Development
Everett P. Dulit, M.D. (M)

83 Cognitive Studies of Child Development
Jules R. Bemporad, M.D. (F)

84 Infantile Sexuality: Fact or Fiction
Leon Salzman, M.D. (LF)

Session IX: Continuing Education *(Videotape Special Session)*

9:00 The Child's View of Family Disturbance
Presented by: Sol Nichtern, M.D. (M); Helen DeRosis, M.D. (F) (Discussant)

10:15 Pathosyntonic Families: Behavior Learning Problems
Presented by: Irvin A. Kraft, M.D. (F); Robert L. Beck, A.C.S.W. (I), Helen DeRosis, M.D. (F) (Discussants)

11:15 Father and Son: Abandonment and Reunion After 41 Years
Presented by: Norman L. Paul, M.D. (F); Helen DeRosis, M.D. (F) (Discussant)

Films IV: Children and Documentaries: Family, School, and Communities

F7 This is the House of Mrs. Levant Graham

F8 He Comes from Another Room

F9 Between Two Rivers

F10 You See I've Had a Life

TUESDAY, MAY 6 1:00 P.M.

Adolf Meyer Lecture

85 Psychiatry's New Challenges
Professor Thomas Adeoye Lambo, M.D., Deputy Director General, World Health Organization, Geneva, Switzerland

TUESDAY, MAY 6 2:30 P.M.

Business Session*

President: *John P. Spiegel, M.D. (F)*
Secretary: *Robert W. Gibson, M.D. (F)*
Call to Order: *John P. Spiegel, M.D. (F)*
Memorial to Deceased Members and Fellows
Announcement of Election of Officers and Trustees: *Morris Kleinerman, M.D. (LF), Chairperson, Committee of Tellers*
Reports to the Membership
Secretary: *Robert W. Gibson, M.D. (F)*
Treasurer: *Jack Weinberg, M.D. (LF)*
Speaker, Assembly of District Branches: *Robert B. Neu, M.D. (F)*
Speaker-Elect, Assembly of District Branches: *Miltiades L. Zaphiropoulos, M.D. (F)*
Medical Director: *Melvin Sabshin, M.D. (F)*
Chairperson, Committee on Constitution and By-Laws: *Winfred Overholser, Jr., M.D. (F)*
Forum
Adjournment

*For voting members only, i.e., Members-in-Training, General Members, Life Members, Fellows, and Life Fellows.

WEDNESDAY, MAY 7 7:00 A.M.

Morning Panels

W1 Vicissitudes of Sexuality in Adolescence and Youth
Moderator: Raoul P. Nadler, M.D. (F)
Panelists: Everett P. Dulit, M.D. (M), Warren G. Gadpaille, M.D. (M), Lothar Gidro-Frank, M.D. (F), Muriel R. Straetz, M.D. (M), Adrian Sondheimer, M.D. (MT)

W2 Is Psychiatry an Endangered Species?
Moderator: James A. Greene, M.D. (M)
Panelists: Robert W. Gibson, M.D. (F), James N. Sussex, M.D. (F), John J. Schwab, M.D. (F), Henry Brackin, Jr., M.D. (F), Hamilton F. Ford, M.D. (LF)

W3 Psychodrama PM (Postmoreno)
Moderator: Neville Murray, M.D. (F)
Panelists: Leon Fine, Ph.D. (I), Karl Hollander, M.A. (I), Martin R. Haskell, Ph.D. (I), Lewis Yablonsky, Ph.D. (I), James Enneis, M.D. (I)

W4 The Funding of Psychiatric Research Training
Moderator: Robert Cancro, M.D. (F)
Panelists: James Eaton, M.D. (M), Daniel X. Freedman, M.D. (F), David A. Hamburg, M.D. (F), Philip Sapir (I), Daniel Offer, M.D. (F)

W5 Jungian Psychology—Man and Woman
Moderator: Harry A. Wilmer, Ph.D., M.D. (F)
Panelists: John W. Perry, M.D. (M), June Singer, Ph.D. (I), Donald F. Sandner, M.D. (M), Joseph Wheelwright, M.D. (F), Jane Wheelwright, M.D. (I)

W6 A New Model for Serving Native Americans
Moderator: Carl A. Hammerschlag, M.D. (M)
Panelists: Barbara Dazen (I), Don Ostendorf, M.S.W. (I), Georginna DeClay (I)

W7 Accountability of a Child Psychiatry Program
Moderator: Jeffrey L. Crawford, Ph.D. (I)
Panelists: Jon A. Shaw, M.D. (M), James A. Granger, M.D. (I), James A. Robinson, M.A. (I)

W8 Child Psychiatry and the Law—Where Are We?
Moderator: Perry B. Bach, M.D. (M)
Panelists: Jann L. Bach, J.D. (I), Elissa P. Benedek, M.D. (F), Rene T. Brant, M.D. (I), Jonathan Brant, J.D. (I), Gail Garinger, J.D. (I)

W9 Atypical Children: Parents as the Change Agent
Moderator: Saul L. Brown, M.D. (F)
Panelists: Garly L. Coleite, Ph.D. (I), Elaine Leader, M.S.W. (I), Shelley Gallenson, M.A. (I), June F. Mayne, M.A. (I)

W10 Sociologists Examine Community Mental Health
Moderator: M. Rue Bucher, Ph.D. (I)
Panelists: Dean Harper (I), Robert M. Emerson (I), Melvin Pollner (I), Patricia Katsky (I)

W11 So You Want to Be an Academic Psychiatrist?
Moderator: David W. Cline, M.D. (F)
Panelists: Frank Johnson, M.D. (F), Robert L. Stubblefield, M.D. (F), John Romano, M.D. (LF), Martin H. Bauman, M.D. (M), Carol Nadelson, M.D. (F)

W12 The Foreign Psychiatric Resident in the U.S.A.
Moderator: Leah Davidson, M.D. (M)
Panelists: Johanna Hoffman, M.D. (F), Christian Caicedo, M.D. (I)

W13 Informed Consent: A First Step Through Film
Moderator: Thomas P. Detre, M.D. (F)
Panelists: Gerald Hogarty, M.S.W. (I), Alan Meisel, J.D. (I), Jeffrey Romoff, M.P.H. (I), Loren H. Roth, M.D. (M)

W14 New Applications of Anthropology to Psychiatry
Moderator: Armando R. Favazza, M.D. (M)
Panelists: Joseph Westermeyer, M.D. (M), Joseph Hartog, M.D. (M), E. Mansell Pattison, M.D. (F), Ronald Wintrob, M.D. (F)

W15 Schizophrenia: Manager-Therapist Team Approach
Moderator: Duke D. Fisher, M.D. (M)

Panelists: Ned N. Cowan, M.D. (M), James S. Grotstein, M.D. (F), George Kalman, M.D. (M), Dr. Susanna Isaacs (I), Albert Mason, M.D. (A)

W16 Hospital Psychiatry—Network, Web, or Maze?
Moderator: Gerald H. Flamm, M.D. (F)
Panelists: Mehadin K. Arafeh, M.D. (F), Donald L. Brown, M.D. (F), Irwin M. Greenberg, M.D. (F), John H. Houck, M.D. (F), James G. Katis, M.D. (F)

W17 National Health Insurance: Private or Public?
Moderator: Marc Galanter, M.D. (M)
Panelists: Robert Okin, M.D. (I), Bertram W. Pepper, M.D. (F), Jay Reibel, M.D. (M), Ralph Wadeson, M.D. (F)

W18 Can Psychiatry Function as Prisoner Advocate?
Moderator: Paul Lowinger, M.D. (F)
Panelists: Bernard Diamond, M.D. (LF), Brian Glick, LL.B. (I), Nathaniel Boothe (I), Wade Hudson (I), Phillip Shapiro, M.D. (LF)

W19 Changing Patterns of Drug Abuse
Moderator: Joyce H. Lowinson, M.D. (M)
Panelists: Pedro Ruiz, M.D. (M), David Smith, M.D. (I), Larry A. Baer (I), John Langrod, M.A. (I)

W20 A New Look at the Menopause and Midlife Years
Moderator: Malkah T. Notman, M.D. (M)
Panelists: Miles Shore, M.D. (F), Pauline Bart, Ph.D. (I), Johanna Perlmutter (I), Joan Zilbach, M.D. (I)

W21 The Alternative of Adolescent-Family Day Treatment
Moderator: Thomas N. Rusk, M.D. (A)
Panelists: Randolph A. Read, M.D. (I), Dorothy Morena, M.S. (I), Marion Temple, M.S. (I), Audrey T. Weiss, M.S. (I), Richard A. Woodaman (I)

W22 Working Abroad: What, Where, and How
Moderator: Zebulon Taintor, M.D. (F)
Panelists: Nathan Kline, M.D. (F), Jimmie Holland, M.D. (F), Irving Blumberg (I)

W23 Mental Health: Children and Youth in the Americas
Moderator: Jorge M. Velasco-Alzaga, M.D. (M)
Panelists: Norman Rosenzweig, M.D. (F), Howard P. Rome, M.D. (LF), Denis Lazure, M.D. (I), Morton Kramer, Sc.D. (HF), Stephen P. Hersh, M.D. (M)

W24 Western Acupuncture: Psychiatric Research, Practice
Moderators: Aristide H. Esser, M.D. (F), Stephen T. Botek, M.D. (M)
Panelists: Howard P. Jenerick, Ph.D. (I), Felix Mann, M.B. B.Chir. (I), David N. Ratnavale, M.D. (M), George A. Ulett, M.D. (F)

W25 A View of Psychiatry in Moscow and Leningrad
Moderator: Joseph J. Baker, M.D. (F)
Panelists: Ruth A. Huggins, M.D. (I), James C. Folsom, M.D. (F), Philip R.A. May, M.D. (F), Charles P. O'Brien, M.D., Ph.D. (M), Thomas A. Williams, M.D. (M)

W26 Biofeedback: Promising New Tool in Psychotherapy
Moderator: Charles S. Adler, M.D. (M)
Panelists: Sheila Morrissey Adler, Ph.D. (I), Arthur E. Gladman, M.D. (M), Jacob Chachkes, M.D. (M), Dezo Levendula, M.D. (M)

W27 Integration: Private Psychiatry and Community Mental Health
Moderator: Robert B. Shapiro, Ph.D. (I)
Panelists: Madeline Gomez, M.D. (M), James Crawford, M.D. (F), Edward B. Perkinson, MA. (I), Jill R. Gardner, Ph.D. (I)

W28 Controlled Studies of Alternative Lengths of Hospitalization for Psychiatric Illness
Moderator: Ira D. Glick, M.D. (F)
Panelists: Bernard Rosen, M.A. (I), Donald F. Klein, M.D. (F), Marvin I. Herz, M.D. (F), John S. Strauss, M.D. (M), William T. Carpenter, Jr., M.D. (M)

WEDNESDAY, MAY 7 9:00 A.M.

Session I: A Centennial Tribute to C.J. Jung

86 Jung's Place in His Historical Setting
Henri F. Ellenberger, M.D. (I)

87 The Growing Influence of Jungian Psychology
Harry A. Wilmer, Ph.D., M.D. (F)

88 Liberating Jung's Sexual Theory
June K. Singer, M.D. (I)

89 Personal Glimpses of Jung the Man
Joseph B. Wheelwright, M.D. (F)

90 Interrelation of Jung's Life and Work
Donald F. Sandner, M.D. (M)

91 Schizophrenia and Jung's Approach
John W. Perry, M.D. (M)

Session II: Depression

92 Detection and Treatment of Childhood Depression
Donald H. McKnew, Jr., M.D. (F), Leon Cytryn, M.D. (M)

93 Depressed Women One Year After Maintenance Therapy
Myrna M. Weissman, Ph.D. (I), Stanislav V. Kasl, Ph.D. (I), Gerald L. Klerman, M.D. (F)

94 Drug Psychotherapy Interactions in Depression
Lino Covi, M.D. (F), Ronald S. Lipman, Ph.D. (I), Renato Alarcon, M.D. (M)

95 Biorhythms and Manic-Depressive Illness
Thomas Wehr, M.D. (I), Frederick K. Goodwin, M.D. (M)

96 EEG Sleep Changes as Predictors in Depression
David J. Kupfer, M.D. (M), F. Gordon Foster, M.D. (I), Louie Reich, M.D. (I), Brian Weiss, M.D. (I)

97 A Suicide Epidemic in a Psychiatric Hospital
Thomas J. Crowley, M.D. (A)

Session III: Psychobiology

98 Central Norepinephrine Function in Man: Vanillylmandelic Acid in Cerbrospinal Fluid
David C. Jimerson, M.D. (MT), Edna Gordon (I), Robert M. Post, M.D. (M), Frederick K. Goodwin, M.D. (M)

99 Urinary 3-Methoxy-4-hydroxyphenyl Glycol in Subtypes of Affective Illness
Frederick K. Goodwin, M.D. (M), Helmut Beckmann, M.D. (I)

100 Growth Hormone Release and Catecholamines in Affective Disease
David L. Garver, M.D. (M), Ghanshyam N. Pandey, Ph.D. (I), Frank D. Jones, M.D. (M), Haroutune Dekirmenjian, Ph.D. (I), Carol T. Hengeveld, M.D. (I), John M. Davis, M.D. (F)

101 Average Evoked Response and Monoamine Oxidase in Affective and Schizophrenic Illness
Monte S. Buchsbaum, M.D. (I), William T. Carpenter, Jr., M.D. (M), Dennis L. Murphy, M.D. (M)

102 Response to Maternal Separation: A Reconsideration
Laurens D. Young, M.D. (I), Jonathan Lewis, M.A. (I), William T. McKinney, Jr., M.D. (M)

103 Diazepam Treatment of Socially Isolated Monkeys
Adele B. Noble, M.D. (MT), William T. McKinney, Jr., M.D. (M), Carol Mohr (I)

Session IV: Education in Mental Health Administration

104 Strategies and Needs of Mental Health Management
William E. Bryon (I)

105 Existing Programs in Mental Health Administration
Barry Greene, Ph.D. (I)

106 Tasks in Education of Mental Health Administrators
Saul Feldman, D.P.A. (I)

107 The Administrator in Response to Social Issues
Alfred M. Freedman, M.D. (F)

Session V: Simon Bolivar Lecture

108 The Cultural Development of Latin America: A Historical Disequilibrium
Germań Arciniegas, Writer, Journalist, Politician, Educator, Diplomat living in Paris, France

Session VI: Violence I

109 Some Effects of TV Violence on Vulnerable Children
Melvin S. Heller, M.D. (F), Samuel Polsky, J.D., Ph.D. (I), Louis Bernstein, Ph.D. (I)

110 The Murdered Child and His Killers
David Kaplun, M.S.W. (I), Robert Reich, M.D. (M)

111 A Violence Clinic: Three Years' Experience
John R. Lion, M.D. (M), Denis Madden, Ph.D. (I), Russell R. Christopher, M.D. (I)

112 The Components of Rapists' Sexual Arousal
Gene G. Abel, M.D. (M), David H. Barlow, Ph.D. (I), Edward B. Blanchard, Ph.D. (I)

113 Social Psychiatric Study of Victims Reporting Rape
Joseph J. Peters, M.D. (F)

114 Rape Accusations in Psychiatric Hospitals
Richard S. Deucher, M.D. (I), Jerrold S. Maxmen, M.D. (I), Toksoz B. Karasu, M.D. (M)

Session VII: Schizophrenia

115 Spouses of Schizophrenics: A Blind Comparative Study
Richard Fowler, M.D. (I), Ming T. Tsuang, M.D. (M)

116 Analysis of Cohort Mortality Risk in Schizophrenia
Betsy Weiner, M.D. (MT), Robert C. Marvit, M.D. (M), Louis Dickinson, M.D. (I)

117 Subjective Experience of Schizophrenia
Harriet Wadeson, A.T.R. (I), William T. Carpenter, Jr., M.D. (M)

118 Visual Attention in Schizophrenia
Robert Cancro, M.D. (F)

119 Loose Associations in the Recovering Schizophrenic
Frank E. Reilly, M.D. (M), Donald M. Quinlan, Ph.D. (I), Martin Harrow, Ph.D. (I), Gary J. Tucker, M.D. (M)

120 Psychosocial Treatment of Acute Schizophrenia
Thomas H. McGlashan, M.D. (M), William T. Carpenter, Jr., M.D. (M), John S. Strauss, M.D. (M)

Session VIII: Special Lecture

121 The Current Status of Behavioral Psychotherapy: Theory and Practice
Isaac M. Marks, M.D., Senior Lecturer, Institute of Psychiatry, Maudsley Hospital, London, England

Session IX: Continuing Education *(Videotape Special Session)*

9:00 The Diagnosis and Treatment of Sex Dysfunctions in Marriage—Sex Therapy Demonstration
Presented by: Helen S. Kaplan, M.D. (F); Barbara Hogan, Ph.D. (I), Orestes Arcumin, M.D. (I), Richard Symons, Ph.D. (I), Merle Kroop, M.D. (MT) (Discussants)

10:30 Simulated Families in Family Therapy Training
Presented by: Samuel M. Silverman, M.D. (MT); Richard Fahy, M.D. (MT) (Discussant)

11:15 Analyzing Police Interventions in Family Crises
Presented by: Dan Gerber, Ph.D. (I); William Matchett, M.D. (M) (Discussant)

Films V: Family Member as Filmmaker: The Search for Roots

F11 Bubby

F12 An Old-Fashioned Woman

F13 Nana, Mom, and Me

F14 Nana, Un Portrait

WEDNESDAY, MAY 7 12:00 NOON

Films VI: Noon Feature: Families Under Stress*

F15 Grapes of Wrath

*This session continues until 1:55 p.m.

Benjamin Rush Lecture

122 The Madness of Art
Joseph Leon Edel, Ph.D., Citizens Professor of English, Department of English, University of Hawaii at Manoa, Honolulu, Hawaii

WEDNESDAY, MAY 7 2:00 P.M.

Session I: Progress Report on the Development of DSM-III*

123 Introduction and Overview to *DSM-III*
Robert L. Spitzer, M.D. (F)

123a Relationship to International Classification of Diseases, 9th ed. (ICD-9)
Morton Kramer, Sc.D. (HF)

124 Description of Psychoses and Affective Disorders Classification
Jean Endicott, Ph.D. (I)

125 Development of *DSM-III:* Personality Disorders
Theodore Millon, Ph.D. (I), Dennis P. Cantwell, M.D. (M)

126 Description of Disorders of Childhood Classification
Paul H. Wender, M.D. (M)

127 Description of Sexual Disorders Classification
Richard Green, M.D. (F)

128 New Disorder: Briquet's Disorder
Robert A. Woodruff, M.D. (F)

129 New Disorders: Panic Disorder and Generalized Anxiety Disorder
Donald F. Klein, M.D. (F)

130 New Disorder: Compulsive Tobacco Smoking
Jerome Jaffe, M.D. (F)

*Because none of the topics discussed in this session will be submitted in written form, the numbers (123–130) will be dropped in the official program and the remaining papers will be renumbered accordingly.

Session II: Issues of Feminist Psychotherapy

131 Unalienating Abortion, Demystifying Depression, and Restoring Rape Victims
Pauline B. Bart, Ph.D. (I)

132 Psychotherapists' Biases Toward Women: Overt Manipulation
Teresa Bernardez-Bonesatti, M.D. (M)

133 The New Feminist Ego-Ideal: Its Function in Feminist Therapy
Ruth Pancoast, M.S.W. (I)

134 Is the *DSM-II* Sexist?
Kathleen B. Unger, M.D. (M)

135 Therapy Groups for Women
Carol S. Wolman, M.D. (M)

Session III: Psychobiology II

136 EEG and Blood Level Relations of Psychoactive Drugs
Max Fink, M.D. (F), Peter Irwin (I)

137 Cocaine, Kindling, and Psychosis
Robert M. Post, M.D. (M), Richard T. Kopanda (I)

138 Prepotent Behaviors in Amphetamine Model Psychosis
Everett H. Ellinwood, Jr., M.D. (F)

139 Immunoglobulin Levels in Psychiatric Patients
Meir Strahilevitz, M.D. (M), Julian Fleischman, Ph.D. (I), Gregory Fischer, M.D. (I), Richard Harris (I), N. Narasimhachari, Ph.D. (I)

140 Environmental Modification of Cerebral Neurons
Roger N. Walsh, M.B. (I), Robert A. Cummins, M.Sc. (I)

141 Neurotransmitters and Chronic Pain
Leighton Huey, M.D. (MT), David S. Janowsky, M.D. (M), Richard Sternbach, Ph.D. (I)

Session IV: PSRO Demonstration in Public Mental Health

142 PSRO Demonstrations: What the Government Bought
Joyce G. Somsak, M.A. (I)

143 Texas: PSRO Problems in a State Hospital System
J. Ray Hays, Ph.D. (I), Joseph C. Schoolar, Ph.D. (F), Melvin Q. Thorne, Jr., M.S.W. (I)

144 Colorado: Impact of PSRO on Hospital Procedures and Patients
Charles Meredith, M.D. (F)

145 Ohio: Mental Hospital Computerized PSRO System
Gordon C. Black, M.H.A. (I), Roy R. Miller, M.D. (I), Gordon F. Ogram, M.D. (F), Paul Y. Ertel, M.D. (I), Theodor Bonstedt, M.D. (F)

146 Implications of PSRO Program for Mental Hospitals
Ben Liptzin, M.D. (M), Michael J. Goran, M.D. (I)

Session V: Violence II

147 Crime and Violence Among Mental Patients
Arthur Zitrin, M.D. (F), Anne S. Hardesty, Ph.D. (I), Eugene I. Burdock, Ph.D. (I), Ann K. Drossman (I)

148 Patterns of Violence Among Psychiatric Inpatients
Richard I. Shader, M.D. (F), Anthony Jackson, M.D. (I), Jerold Stuart Haramatz (I), Paul S. Applebaum (I)

149 Physical Assaults on Psychiatrists by Patients
Denis Madden, Ph.D. (I), John R. Lion, M.D. (M), Manoel Penna, M.D. (M)

150 Assault on the Therapist
Roy M. Whitman, M.D. (F), Beatrice B. Armao, M.S.W. (I), Orin B. Dent, Ph.D. (I)

151 Psychiatric Illness in Homicide Victims
Marijan Herjanic, M.D. (F), David A. Meyers (I)

152 Nursing Aides and Patient Violence
Pauline Levy, R.N. (I), Peter Hartocollis, M.D. (F)

Session VI: Law

153 Mental Health Centers and the Legal System
Herbert C. Modlin, M.D. (LF), Lane Porter, J.D. (I), Richard E. Benson, M.S.W. (I)

154 Involuntary Hospitalization: A Logical Compromise?
Jack A. Wolford, M.D. (F)

155 In Search of a Sane Commitment Statute
Darold A. Treffert, M.D. (F)

156 The Sign-Out Letter: Civil Right and/or Acting Out?
Henry C. Mallard, M.D. (I), Eugene B. Feigelson, M.D. (F)

157 Forensic Psychiatry: Profiles of Sexual Offenders
Fritz A. Henn, M.D. (M), Marijan Herjanic, M.D. (F), Robert H. Vanderpearl, M.D. (M)

158 Child Custody Search for Decision-Making Criteria
John F. McDermott, Jr., M.D. (F), Wen-Shing Tseng, M.D. (M), Alfred M. Arensdorf, M.D. (M), Walter F. Char, M.D. (F)

Session VII: A Forum on Financing of Psychiatric and Mental Health Services*

*No formal papers will be presented.

Session VIII: Diarrhea Syndromes: Pathophysiology and Psychology

159 New Aspects of Pathophysiology of the Gut with Particular Reference to Diarrhea
Sidney F. Phillips, M.D. (I)

160 Paradoxical Motor Disorder in Diarrhea
Marvin Schuster, M.D. (M)

161 Clinical Approach to the Patient with Diarrhea
David Greenbaum, M.D. (I)

Session IX: Continuing Education *(Videotape Special Session)*

2:00 Brief Therapy: Single Parent and End of an Affair
Presented by: Alvin M. Mesnikoff, M.D. (F)

3:30 Emotional Arousal in TV and Film Effects
Presented by: Percy Tannenbaum, Ph.D. (I); James Comer, M.D. (M) (Discussant)

Affect, Altruism, and Aggression: Another View of Emotion and Effects
Presented by: Randall Harrison, Ph.D. (I); James Comer, M.D. (M) (Discussant)

WEDNESDAY, MAY 7 2:00 P.M.

Films VII: Looking with the Camera: Exploitation Versus Privacy

F16 Happy Mother's Day

F17 A Weekend Home

F18 Living with Peter

F19 No Lies

WEDNESDAY, MAY 7 7:30 P.M.

Convocation of Eligible Fellows*

Presiding: *John P. Spiegel, M.D. (F), President*
Grand Marshall: *Norman Q. Brill, M.D. (LF)*
Marshall: *Robert O. Pasnau, M.D. (F)*
Organist: *Joseph H. Stephens, M.D. (F)*
Processional Marches
Induction of Fellows: *Judd Marmor, M.D. (LF), President-Elect*
Presentation of Awards

*An Eligible Fellow is one who attained such status prior to 1975.

The William C. Menninger Memorial Convocation Lecture

162 Psychiatrists' Relationship to Culture Change
Margaret Mead, Ph.D., Curator Emeritus of Ethnology, American Museum of Natural History, New York City

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THURSDAY, MAY 8 7:00 A.M.

Morning Panels

Th1 Borderlines: What Are They, Who Can Treat Them?
Moderator: Miguel Leibovitch, M.D. (M)
Panelists: Jane Bain, M.D. (M), Mardi Horowitz, M.D. (F), Theodore Nadelson, M.D. (F), Cornelia Wilbur, M.D. (LF), Alan Z. Skolnikoff, M.D. (F)

Th2 Women in Academic Psychiatry
Moderator: Carolyn Robinowitz, M.D. (M)
Panelists: Jeanne Spurlock, M.D. (F), Elissa Benedek, M.D. (F), Carol Nadelson, M.D. (F)

Th3 Accountability in Private Practice
Moderator: Rodrigo A. Munoz, M.D. (M)
Panelists: Peter Birkett, M.D. (M), Thomas Flanagan, M.D. (M), William Lovejoy, M.D. (M), James Morrison, M.D. (M)

Th4 Psychiatry in Industry—An Assessment
Moderator: Richard A. DeVaul, M.D. (MT)
Panelists: Herbert Klemme, M.D. (M), Clarence Rowe, M.D. (F), John Turner, M.D. (M), John Wakefield, M.D. (M), Duane Hagen, M.D. (M)

Th5 The Evolution of a Family Therapist
Moderator: Lawrence R. Allman, Ph.D. (I)
Panelists: Beverly Feinstein, M.D. (M), Frank Hoffman, M.D. (I), Dennis Jaffe, Ph.D. (I), Ruth Ellen O'Brien, Ph.D. (I), Frederick J. Duhl, M.D. (M)

Th6 How Does Change Come About in Psychotherapy?
Moderator: Reuven Bar-Levav, M.D. (M)
Panelists: Garfield Tourney, M.D. (F), Raymond E. Buck, M.D. (F)

Th7 Teaching Interpersonal Skills to Medical Students
Moderator: Teresa Bernardez-Bonesatti, M.D. (M)
Panelists: Norman Kagan, Ph.D. (I), John Schneider, Ph.D. (I), Terry Stein, M.D. (MT), Cyril Worby, M.D. (M)

Th8 The Mentally Ill Offender in New York: A Conundrum
Moderator: Hugh F. Butts, M.D. (I)
Panelists: Allen J. Frances, M.D. (M), Michael Greenstein, M.A. (I), Robert A. Liss, Ph.D., J.D. (I), Eugene L. Lowenkopf, M.D. (M)

Th9 The Shape of Things: Art Therapy with Couples
Moderator: Thomas C. Cimonetti, M.D. (M)
Panelist: Gloria Goodman, A.C.S.W. (I)

Th10 Do Doctors Make the Worst Patients?
Moderator: George S. Glass, M.D. (M)
Panelists: Roy N. Aruffo, M.D. (M), Arlene Kaplan Daniels, Ph.D. (I), Jerrold S. Maxmen, M.D. (I), Peter A. Olsson, M.D. (M)

Th11 Postresidency Career Decisions
Moderator: Gary J. Grad, M.D. (M)
Panelists: Jonathan F. Borus, M.D. (M), David R. Hawkins, M.D. (F), Anne M. Seiden, M.D. (M), Joel Yager, M.D. (M), Martin Wasserman, M.D. (F)

Th12 Recovery Helps Patient to Respond to Professional
Moderator: Hanus J. Grosz, M.D. (F)
Panelists: Jerry Dincin, M.S.W. (I), Harvey M. Freed, M.D. (M), Joseph C. Janis, M.D. (M), Milton Greenblatt, M.D. (F), Alexander S. Rogawski, M.D. (F)

Th13 Research in a Clinical Setting

Moderator: Michael Harty, Ph.D. (I)
Panelists: Peter Hartocollis, M.D., Ph.D. (F), Lolafaye Coyne, Ph.D. (I), Robert W. Conroy, M.D. (M), Darrell Bray, M.S.W. (I), Pauline Levy (I)

Th14 Attaining Freedom in Existential Group Therapy
Moderator: Herbert Holt, M.D. (M)
Panelists: George Serban, M.D. (M), Jason Miller, M.D. (F), Herbert Walker, M.D. (M)

Th15 Heroin: Myths, Folklore, and Shibboleths
Moderator: Leon Marder, M.D. (F)
Panelists: T.J. Ungerleider, M.D. (F), G. Keyes, M.D. (I), Lawrence Hart, M.D. (I), Forrest Tennant, M.D. (I)

Th16 History of Psychiatry as an Avocation
Moderator: Otto M. Marx, M.D. (F)
Panelists: Leo H. Berman, M.D. (F), Eric T. Carlson, M.D. (F), David F. Musto, M.D. (M), Henri F. Ellenberger, M.D. (F), Robert H. Sharpley, M.D. (M)

Th17 Mental Health Training in Community Programs
Moderator: E. Mansell Pattison, M:D. (F)
Panelists: Donald Hackenburg, Ph.D. (I), Barbara Hall (I), Raznig Madnelian, M.A. (I), Ellis Wayne, Ph.D. (I), Paul E. Wood, M.D. (M)

Th18 Hospital Discharge Policies Versus Community Services
Moderator: Robert Reich, M.D. (M)
Panelists: Alvin M. Mesnikoff, M.D. (F), Stuart L. Keill, M.D. (F), Robert Daly, M.D. (I), Seymour Gers, M.D. (M)

Th19 Voluntary Sterilization—The Role of the Psychiatrist
Moderator: Maurice D. Steinberg, M.D. (M)
Panelists: Jean-Pierre Lindenmayer, M.D. (M), Warren Miller, M.D. (M), Nancy Kaltreider, M.D. (M), Dorothy Bernstein, M.D. (M)

Th20 Use of Acupuncture in Psychiatry
Moderator: George A. Ulett, M.D. (F)
Panelists: Stephen T. Botek, M.D. (M), Roger Peele, M.D. (F), David N. Ratnavale, M.D. (M), Hsin Chen Tien, M.D. (M), Frank Z. Warren, M.D. (I)

Th21 Evaluation of Treatment of Sexual Disorders
Moderator: Raymond W. Waggonner, M.D. (F)
Panelists: Lawrence Sharpe (I), Judith B. Kuriansky, Ed.M. (I), Jon K. Meyer, M.D. (M), Kurt Ebert, Ph.D. (I), Jim Maddock, Ph.D. (I)

Th22 Santa Clara County Alcoholism Program
Moderator: Fred W. Tempey, M.D. (F)
Panelists: C. Daniel Lindstrom, B.D. (I), Joel Y. Kumparak, R.N. (I), Colleen C. Peyton (I), Robert L. Yoerg (M)

Th23 What Is Good Care of the Dying?
Moderator: Michael Simpson, M.D. (I)
Panelists: John E. Fryer, M.D. (M), Kenneth Spilman (I), Edwin S. Shneidman, Ph.D. (I)

Th24 After Hospitalization—What?
Moderator: Lane Ameen, M.D. (F)
Panelists: Louis B. Fierman, M.D. (F), Robert Rubenstein, M.D. (F), Warren S. Williams, M.D. (F), Phyllis McDowell (I)

Th25 Models of Children's Psychiatric Services
Moderator: Barton Blinder, M.D. (M)
Panelists: G. Pirooz Sholevar, M.D. (M), William M. Young, M.D. (M), Perry Bach, M.D. (M), Henry P. Coppolillo, M.D. (F), Ronald Liebman, M.D. (M)

Th26 Management Issues Within Psychiatry and Medicine
Moderator: David W. Kennard, M.D., Ph.D. (M)
Panelists: Richard Preisman, M.D. (I), William Follette, M.D. (M), Joseph J. Baker, M.D. (F), Herbert S. Ripley, M.D. (LF)

Th27 New Dimensions in Liaison Psychiatry
Moderator: Peritz H. Levinson, M.D. (M)
Panelists: Chase P. Kimball, M.D. (F), William F. Kiely, M.D. (F), Richard H. Rahe, M.D. (F), James Strain, M.D. (M)

Th28 Key Issues in Evaluating Mental Health Programs
Moderator: John S. Strauss, M.D. (M)
Panelists: John J. Schwab, M.D. (F), Haroutun Babigian, M.D. (M), James E. Barrett, M.D. (M), Jack Zusman, M.D. (A), Arthur L. Arnold, M.D. (M)

THURSDAY, MAY 8 9:00 A.M.

Session I: The Acute Schizophrenias: Variant or Misnomer?

163 The Acute Schizophrenias: A History of the Distinction
Robert Cancro, M.D. (F)

164 The Remitting Schizophrenias: A Prospective Follow-Up
George E. Vaillant, M.D. (F)

165 The Adoption Studies and Acute Schizophrenia
Paul H. Wender, M.D. (M), David Rosenthal, Ph.D. (I), John Rainer, M.D. (F), Lawrence Greenhill, M.D. (M), Bruce Sarlin, M.D. (M)

166 Offspring of Schizophrenics: Developmental Studies
Ronald O. Rieder, M.D. (M), David Rosenthal, Ph.D. (I)

167 Schizo-Affective Psychosis and the Schizophrenias
Christiaan D. van der Velde, M.D. (M)

Session II: Rape

168 Sociocultural Aspects of Rape
Barbara Meyerhoff, Ph.D. (I)

169 The Rape Victim on Trial
Margaret J. Gates, Esq. (I)

170 Community Health Care Aspects of Rape
Hope Blacker (I)

171 Development of a Rape Crisis Center in a General Hospital Setting
Sharon McCombie (I), Ellen Bassuk, M.D. (M), Roberta Savitz, M.D. (M), Susan Pell, R.N. (I)

172 Counseling the Rape Victim
Ann Wolbert Burgess, D.N.Sc. (I), Lynda Lytle Holmstrom, Ph.D. (I)

173 Rape—Psychosocial and Family Implications
Carol C. Nadelson, M.D. (F), Malkah T. Notman, M.D. (M)

Session III: Psychotropic Blood Levels and Clinical Responses

174 Clinical Pharmacology in Psychiatry
Joseph Harazti, M.D. (I), Frank D. Jones, M.D. (M), David L. Garver, M.D. (M), John M. Davis, M.D. (F)

175 Pharmacokinetics of Psychotropic Drugs and Clinical Response
Louis A. Gottschalk, M.D. (F), Eugene Dinovo, Ph.D. (I), Robert Biener, M.D. (M), Ernest P. Noble, M.D. (I), Herman Birch, Ph.D. (I)

176 Clinical Pharmacology of Chlorpromazine and Imipramine
George Sakalis, M.D. (I), T.L. Chan, Ph.D. (I), Gregory S. Sathananthan, M.D. (I), Nina Schooler, Ph.D. (I), Solomon C. Goldberg, M.D. (I), Samuel Gershon, M.D. (M)

177 Correlation Between Chlorpromazine Blood Levels
Lenore Rivera-Calimlim, M.D. (I), Henry Narallah, M.D. (M), John S. Strauss, M.D. (M), Louis Lasagna, M.D. (I)

178 Lithium Distribution and Clinical Response
Barney Carrol, M.D. (I)

179 Genetic Control of Lithium Ion Distribution
Elizabeth Dorus, Ph.D. (I), Ghanshayam N. Pandey, Ph.D. (I), John M. Davis, M.D. (F), Haroutune Dekirmenjian, Ph.D. (I)

180 Blood Levels of Psychotropic Agents
Marie Asburgh, M.D. (I)

181 Antidepressant Blood Levels
Per Kragh-Sorenson, M.D. (I)

182 Blood Levels of Imipramine in Depressed Patients
Alexander H. Glassman, M.D. (F), James M. Perel, Ph.D. (I), Michael Shostak, M.D. (M), Shepard J. Kantor, M.D. (M), Joseph L. Fleiss, Ph.D. (I)

183 A Multiple Dose in a Control Study of the Monoamine Oxidase Inhibitor Phenelzine in Depressive Anxiety States
C.L. Ravaris, M.D. (F), A. Nies, M.D. (F), Donald Robinson, M.D. (I), J. Ives, M.D. (M), K. Lamborn, M.D. (I), L. Korson, M.S. (I)

Session IV: The Right to Treatment

184 The Right to Treatment, What It Is and Is Not
Robert L. Sadoff, M.D. (F)

185 Recent Supreme Court Developments and the Goals of the Right to Treatment
Morton Birnbaum, M.D., J.D. (I)

186 Preliminary Report of the Task Force
Richard T. Rada, M.D. (M)

187 The Effect of Right to Treatment on Psychiatry
Bertram W. Pepper, M.D. (F)

188 Position of the APA Commission on Judicial Action
Alan A. Stone, M.D. (F)

Session V: Psychiatry: Interface with Medicine and Surgery

189 The Gap Between the Psychiatric and Medical Model
Rita R. Rogers, M.D. (F)

190 Long-Term Follow-Up of Stereotaxic Amygdalotomy
Iver F. Small, M.D. (F), Robert F. Heimburger, M.D. (I), Michael H. Anderson (I), Victor Milstein, Ph.D. (I), Joyce G. Small, M.D. (F)

191 Behavioral Changes Following Surgery for Obesity
Mark John Mills, J.D. (I), Albert J. Stunkard, M.D. (F)

192 Psychiatric Appraisal of Surgery for Superobesity
Pietro Castelnuovo-Tedesco, M.D. (F), Douglas Schiebel, Ph.D. (I)

193 Preventing Emotional Problems in a Dialysis Team
Frederick E. Fried, M.D. (M), Louesa R. Danks, A.C.S.W. (I), Carolyn S. Beavert, M.A. (I)

194 Severe Trauma: The Experience of Unconsciousness
Nathan Schnaper, M.D. (F), R. Adams Cowley, M.D. (I)

195 Headache Treatment with Autoacupuncture
Howard D. Kurland, M.D. (M)

Session VI: Children

196 Linguistic Lags in Vulnerable and Autistic Children
Sheldon M. Frank, M.D. (M), Doris Ann Allen, Ed.D. (I), Lorrayne Stein (I), Beverly Myers (I)

197 Early Infantile Autism and Schizophrenia
Peter D. King, M.D. (F)

198 Behavior Characteristics of Children with Chronic Nonspecific Diarrhea
Esther H. Wender, M.D. (I), Paul H. Wender, M.D. (M), Fred B. Palmer, M.D. (I), John J. Herbst, M.D. (I)

199 Affective, Atopic Disorders, and Cyclic AMP
Helen Johns Ossofsky, M.D. (A)

200 An Analysis of Self-Injury in Lesch-Nyhan Disease
Lowell T. Anderson, Ph.D. (I), Murray Alpert, Ph.D. (I), Joseph Dancis, M.D. (I)

201 Latency: Fact or Fiction?
Samuel S. Janus, Ph.D. (I), Barbara E. Bess, M.D. (M)

202 Ritalin Versus Behavior Therapy in Hyperactive Children
Rachel Gittelman-Klein, Ph.D. (I), Donald F. Klein, M.D. (F)

Session VII: Administration and Consultation

203 Breakthrough in Nonhospital Psychiatric Insurance
Daniel Blain, M.D. (LF), Melvin Glasser, LL.D. (I)

204 Insuring Intensive Psychotherapy
Steven S. Sharfstein, M.D. (M), Howard L. Magnas, M.A. (I)

205 Psychiatrists in Community Mental Health Centers
Stanley S. Robin, Ph.D. (I), Morton O. Wagenfeld, Ph.D. (I)

206 Mental Health Center Type and Director's Ideology
Jerry Wacks, M.D. (A), Maurice Miller, M.S.W. (I), Stanley S. Robin, Ph.D. (I), Morton O. Wagenfeld, Ph.D. (I)

207 Problems in Organizational Consultation in the U.S. Army
Maj. Edward K. Jeffer, MC (M)

208 Doctors and Race Relations: A Consultation Quandry
John F. Greden, M.D. (M), Thomas E. Guyden, M.D. (I), Robert Miller, M.D. (M)

209 (Paper Withdrawn)

Session VIII: New Research

The presentations in New Research sessions consist of brief descriptions of recently collected research data submitted after the deadline for printing this program. Program leaflets containing all of the details of the presentations will be available at the registration desk.

Session IX: Continuing Education *(Videotape Special Session)*

9:00 The Role of the Family in the Treatment of Intractable Asthma
Presented by: Ronald Liebman, M.D. (I), Salvador Minuchin, M.D. (I)

10:00 The Dynamics of a Normal, Effectively Functioning Family Over Time
Presented by: Lyman C. Wynne, M.D. (F), Carl Whitaker, M.D. (LF); Jerry M. Lewis, M.D. (F) (Discussant)

Films VIII: Film Memorials and Biography

F20 Grief

F21 Psychiatrist in the Community

F22 The Story of Carl Gustav Jung

THURSDAY, MAY 8 12:00 NOON

Films IX: Noon Feature: Families Under Stress*

F23 Castle of Purity

*This session continues until 1:50 p.m.

THURSDAY, MAY 8 2:00 P.M.

Session I: Psychological Aspects of the Arab-Israeli War

210 Psychiatry and Foreign Affairs
Howard P. Rome, M.D. (LF)

211 Emotional Climate of Israeli Society Since October 1973
Rita Rogers, M.D. (F)

212 The Arab-Israeli Conflict and the Development of Arab Ego Identity
John Racy, M.D. (M)

213 New Perceptions of an Old Conflict
Philip Stoddard, Ph.D. (I)

Session II: Sex, Therapy, and Foreign Psychiatry

214 Arenas of Conflict: Marriage and the Marriage Bed
Ellen Frank, M.A. (I), Carol Anderson, M.S.W. (I), David J. Kupfer, M.D. (M)

215 Sex Therapy: Training and Accreditation
Jon K. Meyer, M.D. (M)

216 Sex Roles in Marriage and Marital Therapy
Carol M. Anderson, M.S.W. (I), Susan Schilling Meisel, M.S.W. (I), Thomas P. Detre, M.D. (F)

217 Integrating the Roles of Psychiatrist, Wife, Mother
Maryonda Scher, M.D. (F), Elissa P. Benedek, M.D. (M), Ardis Candy, M.D. (M), Kira Carey, M.D. (I), Janet Mules, M.D. (M), Bernice Sachs, M.D. (M)

218 Employee Stigma: Added Cost of Psychotherapy
Gerald A. Melchiode, M.D. (M), Milt Jacobson (I)

219 Swedish Psychiatry: The Awkward Age
Jordan H. Lachman, M.D. (F), Mats Gruvstad, M.D. (I), Louis Aarons, Ph.D. (I)

220 Psychosocial Implications of New Guinean Independence
Burton Gyrth Burton-Bradley, M.D. (I)

Session III: Lithium in Depression

221 Lithium in the Treatment of Depression
Joe Mendels, M.D. (M)

222 Tricyclics Versus Lithium Prophylaxis of Depression
Robert R. Prien, Ph.D. (I)

223 Lithium Carbonate Prophylaxis Failure
David L. Dunner, M.D. (A), Joseph L. Fleiss, Ph.D. (I), Ronald R. Fieve, M.D. (F)

224 Lithium Prophylaxis of Three Depressive Subtypes
Ronald R. Fieve, M.D. (F), David L. Dunner, M.D. (A), Frank Stallone, Ph.D. (I), Turkan Kumbarachi, Ph.D. (I), Joseph L. Fleiss, Ph.D. (I)

Session IV: Mental Hospitals

225 Breaking the Revolving Door Syndrome
Carl I. Cohen, M.D. (I), Willemel Sichel, A.C.S.W. (I), Dirk Berger, M.D. (M)

226 Phase Out of Mental Hospitals in America
Milton Greenblatt, M.D. (F), Elizabeth Glazier, M.P.H. (I)

227 Short Versus Long Hospitalization: One-Year Follow-Up
Ira D. Glick, M.D. (F), William A. Hargreaves, Ph.D. (I), Joan Drues, M.A. (I), Jonathan A. Showstack (I)

228 A Five-Year Study of Brief Hospitalization
Arthur Schwartz, M.D. (M), Marshall Swartzburg, M.D. (I)

229 Predicting Length of Stay in a Short-Term Unit
Robert J. Albers, Ph.D. (I)

230 Day Hospital Treatment of Terminally Ill Patients
Stanley E. Slivkin, M.D. (M)

Session V: Behavior Modification

231 Parental Perceptions of Parent and Child Behavior
Eleanor D. Dibble, D.S.W. (I), Donald J. Cohen, M.D. (M), Jane M. Grawe (I)

232 Cardiac Neurosis Treated Behaviorally
Boris G. Rifkin, M.B. (F)

233 Concurrent Separate Psychodynamic Behavior Therapy
Robert C. Smith, M.D. (MT), Robert Taylor Segraves, M.D. (M)

234 Behavior Modification: A Boon to Child Psychiatry?
Nicholas Fish, M.D. (F), Anne Meyers (I)

235 Siblings as Therapists: A Behavioral Approach
Nancy A. Brown, M.S.W. (I), Dennis P. Cantwell, M.D. (M)

236 Biofeedback: An Adjunct for Psychiatric Treatment
Redford B. Williams, Jr., M.D. (I), John M. Rhoads, M.D. (F)

Session VI: Adolescence

237 Evolution of Behavior Disorders into Adolescence
Alexander Thomas, M.D. (F), Stella Chess, M.D. (F)

238 The Treatment of Anorexia Nervosa
Alexander R. Lucas, M.D. (F), Jane Watson Duncan, M.D. (I), Violet Piens, R.N. (I)

239 Familial Hypothalamic Disorder in Anorexia Nervosa
Katherine A. Halmi, M.D. (M), Andrea L. Struss, M.D. (I), Solomon C. Goldberg, Ph.D.

240 Behavior of Hypersexual Delinquent Girls
Jerome D. Goodman, M.D. (M)

241 Volunteer Adolescents in Adolescent Group Therapy
Stuart Fine, M.B. (I), Graham Knight-Webb, M.B. (I), Karen Hayes, M.S.W. (I)

242 Pseudosexuality in Feminist Students
Zira De Fries, M.D. (F)

Session VII: Psychological Research

243 Why Prisoners Participate in Research
Jeffrey S. Rubin (I), John R. Lion, M.D. (M), Russell R. Monroe, M.D. (F), George U. Balis, M.D. (M)

244 Are Research Interviews Valid?
William T. Carpenter, Jr., M.D. (M), Michael H. Sacks, M.D. (M), John S. Strauss, M.D. (M), John J. Bartko (I)

245 Reliability and Validity of a Placebo Test
Elmer L. Struening, Ph.D. (I), Arthur K. Shapiro, M.D. (F), Elaine Shapiro, Ph.D. (I)

246 Human Nonverbal Memory: A Quantitative Approach
H.E. King, Ph.D. (I)

247 Psychosis, Thought Disorder, and Regression
Nancy C. Andreasen, M.D. (M), Pauline S. Powers, M.D. (I)

248 Do Dreams Have Meaning? A Scientific Inquiry
Thomas Roth, Ph.D. (I), Milton Kramer, M.D. (F), Robert Hlasny, M.A. (I), Gerard Jacobs (I)

Session VIII: New Research

The presentations in New Research sessions consist of brief descriptions of recently collected research data submitted after the deadline for printing this program. Program leaflets containing all of the details of the presentations will be available at the registration desk.

Session IX: Continuing Education *(Videotape Special Session)*

2:00 Marriage Contracts—Their Use in Couples Therapy
Presented by: Clifford J. Sager, M.D. (F)

3:00 The Therapist Couple Working with the Patient Couple
Presented by: John P. Briggs, M.D. (F), Muriel A. Briggs (I)

4:00 Steps Toward Differentiation of Self in Marriage
Presented by: Murray Bowen, M.D. (F)

Films X: Member's Film Forum

F24 Aides Are People Too

F25 Sai Baba

F26 Working with People Called Patients

F27 And the Walls Came Tumblin' Down

F28 Working Out

THURSDAY, MAY 8 8:00 P.M.

Films XI: Special Evening Feature*

F29 Scenes From A Marriage

*This session continues until 11:00 p.m.

Evening Panels

AA What's the Best Way to Teach Sex in Medical School?
Moderator: David W. Preven, M.D. (M)
Panelists: Robert Becker, M.D. (M), Harold Lief, M.D. (F), Maj-Britt Rosenbaum, M.D. (M), Diane Settlage, M.D. (I), Herbert Vandervoort, M.D. (F)

BB Behavioral Approaches to Alcoholism
Moderator: John A. Ewing, M.D. (F)
Panelists: Edward Gottheil, Ph.D., M.D. (F), G. Alan Marlatt, Ph.D. (I), Alfonso Paredes, M.D. (F)

CC Process of Systems and Program Consultation
Moderator: Philip M. Margolis, M.D. (F)
Panelists: John M. Anderson, M.D. (F), William B. Beach, Jr., M.D. (F), James Q. Simmons, III, M.D. (F), George Zubowicz, M.D. (F), Leonard J. Ganser, M.D. (F)

DD "The Female Psyche" as a Legal Disability
Moderator: Sharon Kaufman-Diamond, M.D. (M)
Panelists: Barbara E. Brudno, J.D. (I), Carole E. Goldberg, J.D. (I), Natalie Hoffman, J.D. (I), Karen J. Kaplowitz, J.D. (I)

EE Free Clinics Revisited
Moderator: Ricardo Galbis, M.D. (M)
Panelists: Charles Bien (I), Nick Azzatto (I), Pedro Ruiz, M.D. (M)

FF Lesbianism—What Does She See in Her?
Moderator: Nanette K. Gartrell (I)
Panelists: Richard Green, M.D. (F), Laud Humphreys, Ph.D. (I), Ruth McGuire, Ph.D. (I), Barbara Price (I), Pepper Schwartz, Ph.D. (I)

GG Religious Alternatives and Complements to Therapy
Moderator: Alice Dean Kitchen, M.D. (M)
Panelists: E. Mansell Pattison, M.D. (F), Charles Crown, M.D. (M), Armand M. Nicholi, II, M.D. (F)

HH Three Years with a Leaderless Couples Group
Moderators: F.M. Pepitone-Rockwell, Ph.D. (I), D. Rockwell, M.D. (F)
Panelists: M. Derrico (I), R. Derrico, M.S.W. (I), P. Hersch, Ph.D. (I), M. Hersch (I), C. Folkins, Ph.D (I), K. Folkins (I), R.J. Spensley, M.D. (F), J. Spensley (I), R. Myers-Vando, M.S.W. (I), A. Vando, Ph.D. (I)

II Liaison Psychiatry: What It Might Be and How
Moderator: Arthur B. Schuller, M.D. (I)
Panelists: Chase P. Kimball, M.D. (F), F.P. McKegney, Jr., M.D. (F), Donald H. Naftulin, M.D. (F), Joe P. Tupin, M.D. (F)

JJ Demonstration Trial: Family Suit for Psychic Damage
Moderator: Dennis F. Koson, M.D. (MT)
Panelists: Ames Robey, M.D. (F), Robert L. Sadoff, M.D. (F)

KK Cognitive and Psychodynamic Aspects of Adolescence
Moderator: Mona Bleiberg, M.D. (M)
Panelists: Malkah Notman, M.D. (M), Carol C. Nadelson, M.D. (F), Joan Stein, Ed.D. (I)

LL Medical Education in Alcohol and Drug Abuse
Moderator: Marc Galanter, M.D. (M)
Panelists: Roland M. Atkinson, M.D. (M), Donald I. Davis, M.D. (M), James A. Halikas, M.D. (M), Joseph Westermeyer, M.D. (M)

MM Comprehensive Family Therapy Training

Moderator: Evaristo Gomez, M.D. (F)
Panelists: Robert E. Rutledge, M.S.W. (I), Patricia M. Barger, Ph.D. (I), Rita N. Dominguez, M.S.W. (I), Robin L. Condro, M.S.W. (I)

NN Cotherapists Enter the Family: Problems and Progress
Moderator: Melvin Roman, Ph.D. (I)
Panelists: Lawrence Grolnick, M.D. (M), Selma Belenky, C.S.W. (I), Peter Dunn, M.D. (I), Irene Labourdette, M.D. (I)

OO Questions and Answers from Analytic Group Therapy
Moderator: Martin Grotjahn, M.D. (LF)
Panelist: John Peck, M.D. (F)

PP Judicial Diversion: Three Family Crisis Therapy Models
Moderator: Randolph A. Read, M.D. (I)
Panelists: Audrey T. Weiss, M.S. (I), George A. Sargent, Ph.D. (I), Jeanne McAlister, C.A.C. (I), Richard Jacobsen, M.D. (I), Vi Thomas (I)

QQ The Suicidal Doctor: The Family's Therapeutic Role
Moderator: Douglas A. Sargent, M.D. (F)
Panelists: Thomas A. Petty, M.D. (F), Robert Schopbach, M.D. (F), Herbert Raskin, M.D. (F), Viggo W. Jensen, M.D. (F)

RR Heroin Abuse: Community Mental Health Challenge
Moderator: Jacob Schut, M.D. (M)
Panelists: Anthony F. Santore, A.C.S.W. (I), Herbert Diamond, M.D. (M), Billie Joe Thurmond (I)

SS Rural Mental Health—Community Entry and Acceptance
Moderator: William C. Shriner, M.D. (M)
Panelists: Thomas Henderson, Ph.D. (I), Anne Doherty, Ph.D. (I), Phyllis Phenis (I), Nancy Oehler, M.D. (I)

TT Let Sleeping Watchdogs Lie? APA Issues and Answers
Moderator: Frederick J. Stoddard, M.D. (M)
Panelists: Kent Ravenscroft, M.D. (M), E. Fuller Torrey, M.D. (M), Kenneth Woodrow, M.D. (M)

UU Humility Is the Only Obstacle—Perspective on Sex Therapy 1975
Moderator: Philip E. Veenhuis, M.D. (M)
Panelists: Joanne Veenhuis (I), Alexander N. Levay, M.D. (F), Harvey L.P. Resnik, M.D. (F), Audrey Resnik (I), Armando de Moya, M.D. (I), Dorothy de Moya (I), Phillip Sarrel, M.D. (I), Lorna Sarrel (I), John B. Reckless, M.D. (F)

VV Training Foreign Medical Graduates for Practice in America or Abroad
Moderator: Jagdish S. Teja, M.D. (M)
Panelists: Tsung-yi Lin, M.D. (F), Ronald Chen, M.D. (F), Ronald C. Simons, M.D. (F), Thomas H. Maretzki, Ph.D. (I), Desmong Fung, M.D. (I), Salman Akhtar, M.D. (I)

WW Professional Association Review of State Health Programs?
Moderator: C. Downing Tait, M.D. (F)
Panelists: Marvin I. Herz, M.D. (F), William I. Malamud, M.D. (F), Magno Ortega, M.D. (I)

XX Borderline and Narcissistic Cases in Group Therapy
Moderator: Donald A. Shaskan, M.D. (LF)
Panelists: Edward L. Pinney, Jr., M.D. (F), Clifford J. Sager, M.D. (F), Hyman Spotnitz, M.D. (LF), Aaron Stein, M.D. (F)

YY Impact of the Equal Rights Amendment on Psychiatry
Moderator: Ann Laycock Chappell, M.D. (M)
Panelists: Wendy Webster Williams, J.D. (I), Jeanette Black, R.N. (I), Jeanne Spurlock, M.D. (F), Seymour Halleck, M.D. (F), Anne M. Seiden, M.D. (M)

ZZ Models of Childrens' Psychiatric Services
Moderator: Barton J. Blinder, M.D. (M)
Panelists: Dane Prugh, M.D. (M), David Albin, M.D. (M), Mark Markowitz, M.D. (M), Howard E. Hansen, M.D. (F), William Loomis, M.D. (M)

ZZ1 Conflicts Between Couples: A Transactional Analysis
Moderator: John M. Dusay, M.D. (F)
Panelists: John J. O'Hearne, M.D. (F), Lillian O'Hearne, M.D. (I), Carlton D. Thornwall, M.D. (I), Ruth McLendon, M.S.W. (I), Barry Hirsch, LL.B. (I)

ZZ2 The Emerging Native American: Problems and Development
Moderator: James T. Barter, M.D. (F)
Panelists: Robert L. Bergman, M.D. (M), Humphrey C. Townsley, M.D. (M), James H. Shore, M.D. (M), Carolyn Attneave, Ph.D. (I)

FRIDAY, MAY 9 9:00 A.M.

Session I: A Death in the Family

249 Clinical Experience with Death in the Family
Elisabeth Kübler-Ross, M.D. (M)

250 When Children Die
Doris Howell, M.D. (I)

251 Family Systems and Death
Claus B. Bahnson, Ph.D. (I)

252 The Fatal Pathology of the Family Secret
E. Mansell Pattison, M.D. (F)

Session II: Treatment of Marital Disharmony and Systems Theory

253 Mate Selection Determinants and Marital Disharmony
Frederick J. Duhl, M.D. (M), Bunny S. Duhl (I)

254 Redecisions in Marital Therapy
Robert L. Goulding, M.D. (M), Ruth McClendon, M.S.W. (I), George McClendon, M.B.A. (I)

255 Treatment of Marital Disharmony Where One Spouse Has a Primary Affective Disorder
Bernard L. Greene, M.D. (LF), Noel Lustig, M.D. (M), Ronald R. Lee, Ph.D. (I)

Session III: Psychopharmacology

256 Antidepressant Effects of Sleep Deprivation
Robert H. Gerner, M.D. (MT), Robert M. Post, M.D. (M), Frederick K. Goodwin, M.D. (M), David C. Jimmerson, M.D. (MT)

257 Effects of Marijuana on Flying Ability
David S. Janowsky, M.D. (M), Martin Meacham (I), Michael Schoor (I), Jack Blaine, M.D. (MT)

258 Delta-9-THC and Nonverbal Communication in Monkeys
Robert E. Miller, Ph.D. (I), Allyn C. Deets, Ph.D. (I)

259 Effect of Drug Ritual Changes on Schizophrenics
Rodney W. Burgoyne, M.D. (M)

260 Tricyclic Effect on Butaperazine Plasma Levels
M. Khaled El-Yousef, M.D. (M), Hal Manier, M.S. (I)

261 A Follow-Up of Tourette's Syndrome in 77 Patients
Ruth Dowling Brunn, M.D. (M), Arthur K. Shapiro, M.D. (F), Richard D. Sweet, M.D. (I), Elaine Shapiro, Ph.D. (I), Gail E. Solomon, M.D. (I), Henriette L. Wayne, M.D. (M)

Session IV: Impact of Community Mental Health Center Legislation on American Psychiatry

262 CMHC Legislation: Flight of the Phoenix
Frank M. Ochberg, M.D. (M)

263 Mental Health and Elderly
Gene D. Cohen, M.D. (M)

264 Community Alternatives to Institutional Care
Lucy D. Ozarin, M.D. (F)

265 The CMHC and Children
Michael F. Fishman, M.D. (F)

266 Quality Assurance and Public Involvement in CMHCs
Louis E. Kopolow, M.D. (M)

Session V: Family Systems and Individual Ego Functioning

267 Healthy Families

Jerry M. Lewis, M.D. (F), W. Robert Beavers, M.D. (F), John T. Gossett, Ph.D. (I), Virginia Austin Phillips (I)

268 The Midrange Family
W. Robert Beavers, M.D. (F), Jerry M. Lewis, M.D. (F), John T. Gossett, Ph.D. (I), Virginia Austin Phillips (I)

269 The Severely Dysfunctional Family
Stephen Fleck, M.D. (F)

Session VI: Residency Training

270 The Failure of American Academic Psychiatry
Gene H. Borowitz, M.D. (F), Eduardo Val, M.D. (F), Anne M. Seiden, M.D. (M)

271 Residency Without Internship
Elliott L. Markoff, M.D. (F)

272 Competency-Based Psychiatric Education
Harvey M. Weinstein, M.D. (M), Michael L. Russell, Ph.D. (I)

273 Stress and Growth Factors in Residency Training
Zebulon Taintor, M.D. (F), Michael Pearson, M.D. (I), Murray Murphy, M.D. (MT)

274 The Emotionally Disturbed Psychiatric Resident
Maj. Andrew T. Russell, MC (M), Robert O. Pasnau, M.D. (F)

275 Residency Training and Personal Development Differ
David Spiegel, M.D. (M), Henry Grunebaum, M.D. (M)

276 Psychotherapy Fees and Residency Training
Stefan A. Pasternack, M.D. (M), Philip Treiger, M.D. (I)

Session VII: Biofeedback: Clinical Applications

277 Treatment of Migraine: A Rationale for Biofeedback
Elmer E. Green, Ph.D. (I), Alyce M. Green (I)

278 Biofeedback in General Psychiatric Practice
Robert H. Barnes, M.D. (F), Richard E. McKenzie, Ph.D. (I)

279 Visceral Control: Some Implications for Psychiatry
Bernard T. Engle, Ph.D. (I)

280 Biofeedback and Psychotherapy
Melvyn R. Werbach, M.D. (M)

281 A Biofeedback Approach to Psychosomatic Illness
Arthur E. Gladman, M.D. (F), Norma Estrada (I)

Session VIII: Continuing Education *(Videotape Special Session)*

9:00 Death in Adolescence
Presented by: Alayne Yates, M.D. (M)

10:00 Childhood Cancer: The Family and the Professionals
Presented by: Edward H. Pakes, M.D. (M); Marilyn Strong, M.D. (I) (Discussant)

11:00 The Family Evaluation Team and Clinical Management
Presented by: Saul L. Brown, M.D. (F)

Films XII: Filming Families in Other Cultures

F30 Joking Relationship

F31 Cree Hunters of Mistassini

F32 Tidikawa and Friends

The Sixth Annual Seymour Vestermark Memorial Lecture

282 Continuing Education in Psychiatry
Hugh T. Carmichael, M.D. (LF), Professor Emeritus, University of Chicago, and former Director, Office of Continuing Education for Psychiatrists, American Psychiatric Association

Listed below are the names of those individuals presenting scientific papers and those participating in panel discussions and videotape sessions.

Numbers. Numbers following the names refer to paper numbers rather than to pages.

Morning Panels. Morning panels are designated by the following abbreviations: the letters "Tu" (Tuesday), "W" (Wednesday), or "Th" (Thursday), followed by the number of the morning panel. Thus the abbreviation "Th4" refers to panel number 4 on Thursday morning.

Evening Panels. Evening panels are designated by the following abbreviations: either a single letter for panels on Monday evening or double letters for panels on Thursday evening. Thus the abbreviation "B" refers to the second panel listed on Monday evening, and the abbreviation "BB" refers to the second panel listed on Thursday evening.

Video Sessions. The program contains six video sessions, one each on Monday afternoon, Tuesday morning, Wednesday morning, Wednesday afternoon, Thursday morning, Thursday afternoon, and Friday morning. These are designated by the following abbreviations: the letters "M" (Monday), "Tu" (Tuesday), "amW" (Wednesday morning), "pmW" (Wednesday afternoon), "amTh" (Thursday morning), or "pmTh" (Thursday afternoon), followed by the letters "Vid" (Video) and the session number. Thus "amThVidIX" refers to Session IX on Thursday morning, which is a videotape session.

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Advance registration is available. For a schedule of fees, please see p. 321 under "Registration."

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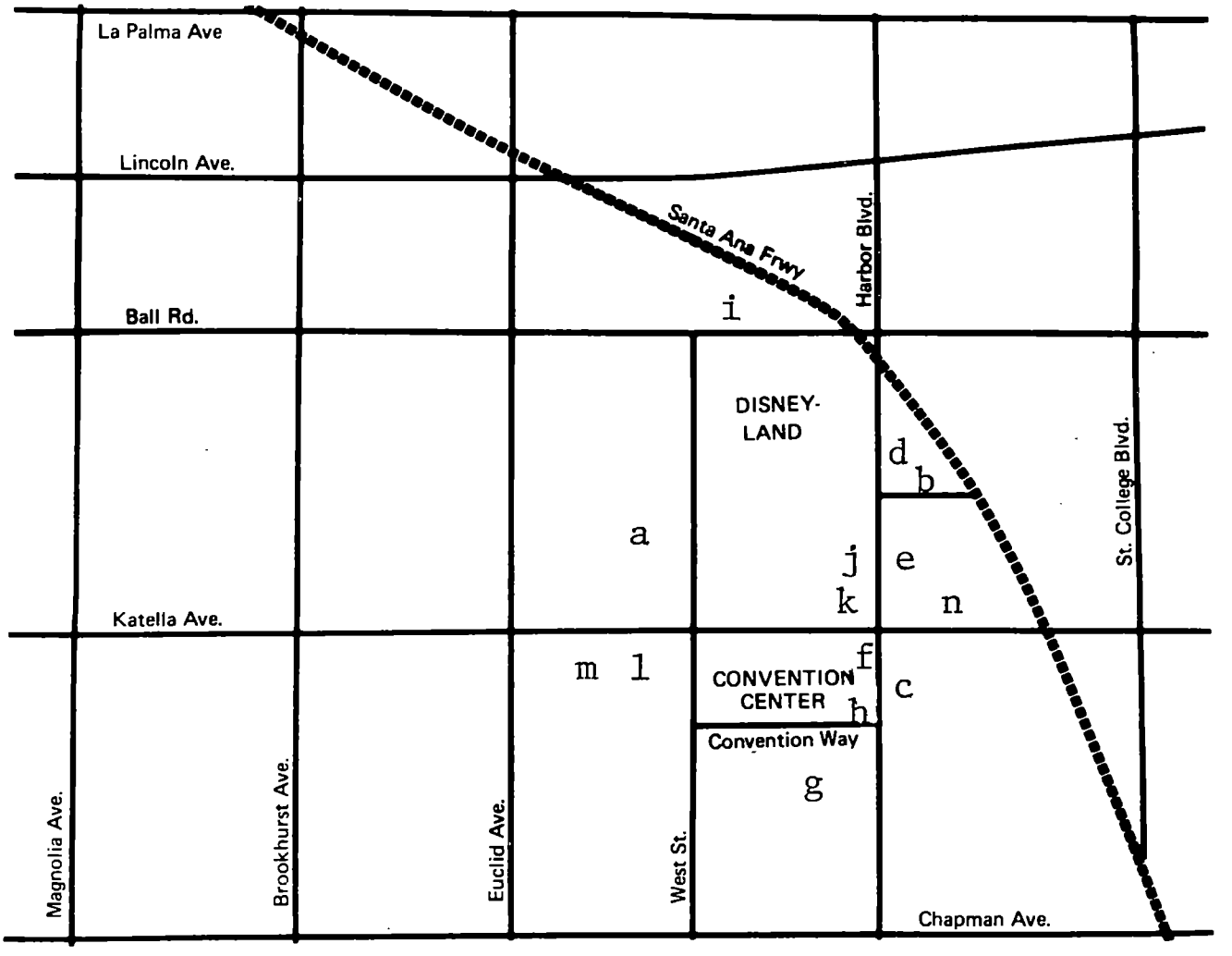
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i. Sheraton Anaheim	22	28	45–65	
j. Cosmic Age	16	20	40	
k. Galaxy	16	20	40	
l. Inn of Tomorrow	16	20	40	
m. Space Age	16	20	40	
n. Westward Ho	15	24		

*Rates for third person in room are $4.00 and up.

MAP SHOWING LOCATION OF HOTELS



Workshop on Writing for Scientific Journals

The 1975 annual meeting will feature the second annual workshop on writing for scientific journals, to be held from 9:00 a.m. to 5:00 p.m. on Sunday, May 4 (the day before the annual meeting begins). The workshop, cosponsored by APA and the American Medical Writers Association (AMWA), will offer practical information and instruction on four subjects: common writing faults, organizing medical reports, getting your words on paper, and submitting a manuscript. Work assignments, which will be sent to registrants before the meeting, will form the basis for initial discussions during the workshop sessions.

The course will begin with brief introductory lectures by the AMWA faculty, who include Charles G. Roland, M.D., chairman of the Department of Biomedical Communications, the Mayo Foundation; Barbara G. Cox, medical writer, Instructional Development Section, the Mayo Foundation; and Martha Tacker, Ph.D., free-lance medical writer and editor. Following the lectures there will be small-group discussion on the four basic subjects. The workshop will conclude with a panel discussion in which participants will have the opportunity to question the editors of several psychiatric journals.

The opening session of the workshop will be held in the Cerritos Room of the Disneyland Hotel.

Registration is limited to 40 participants. All applications for participation must be received by April 7; the registration fee is $65.

For further information on registration write to Charles G. Roland, M.D., Department of Biomedical Communications, the Mayo Foundation, Rochester, Minn. 55901.

Workshop on Writing for Scientific Journals

REGISTRATION FORM

Sunday, May 4, 1975

Print name and mailing address below and send this form, along with your check for $65.00 made payable to the American Medical Writers Association, to Charles G. Roland, M.D., Department of Biomedical Communications, the Mayo Foundation, Rochester, Minn. 55901. NOTE: No refunds for cancellation will be made after April 7.

Name _____

Address _____

_____

Position Statement on the Role of Confidentiality in Volunteer Military Drug Abuse Treatment Programs

This statement was approved by the Board of Trustees of the American Psychiatric Association at its December 14-15, 1974, meeting upon recommendation of the Council on Professions and Associations. It was prepared by the Task Force on Confidentiality as It Relates to Third Parties.[1]

THE AMERICAN PSYCHIATRIC ASSOCIATION was much encouraged and pleased when the President and the Department of Defense adopted a policy of viewing the drug abuser as a medical problem, while still maintaining its efforts to eradicate the traffic in drugs. A treatment program written by the military establishment must be seen as positive action directed toward furthering the primary mission of the armed forces.

The role of confidentiality in successful psychiatric treatment has been well established. The development of a positive treatment atmosphere for a voluntary rehabilitation program for drug abusers is partially contingent upon the degree to which a psychiatrist can assure the patient of the confidentiality of his disclosures. The real or threatened adverse consequences of disclosure may cause personnel to avoid seeking treatment altogether or not to cooperate fully in the treatment regime.

As civilian psychiatrists, we can only recommend those things concerning confidentiality that we feel will help lead to an effective voluntary military drug abuse treatment program. In any program offering confidentiality, the limits of confidentiality must be defined. Any promise of nonpunitive action must truly be nonpunitive; otherwise, the subsequent disillusionment of the treated person will create a destructive reaction to both his treatment and the program in general. There have been examples of unsuccessful treatment programs where the limits of confidentiality were not well defined and, indeed, did not prevent the occurrence of secondary punitive action. Protection for those honestly seeking help will provide a more effective program and increase the motivation for help.

The act of volunteering should grant protection only for a confidential evaluation prior to the volunteer's acceptance into the drug abuse treatment program and for ongoing participation and cooperation in the program. In recommending this amnesty, we do not imply that personnel in treatment are immune from the consequences of unacceptable behavior secondary to or not related to the fact of treatment.

Being labeled a drug abuser is punitive in itself. For that reason, as far as possible all medical records relating to treatment should be held inviolate in the medical treatment sector. In military programs as in civilian programs, both the patient and psychiatrist recognize that, at various times and for various reasons, this confidentiality cannot be absolute. The medical unit and the command unit must be aware of each other's needs and responsibilities and must keep each other adequately informed of factors that would represent a hazard to the treatment of the individual or to the command's mission. (Army regulation AR-40-42 is an example of these safeguards.)

Three special considerations that have been brought to our attention could also seriously and adversely affect the viability of drug abuse treatment programs.

1. Compromising conditions for entering the treatment program should be avoided. For example, making amnesty or treatment conditional on the individual's becoming an informer will seriously affect the creditability of the program. (The Army has taken note of this in Army regulation AR-40-42, paragraph 6G, which specifically deals with this point.)

2. There have been reports of damaging breaches of the patient's confidentiality by the release of critical information to civilian sources after the individual's discharge from military duty. One way of exposing individuals who have been in drug treatment programs after their separation from service has been the SPN number on discharge papers. We would urge reexamination of the policy of using these SPN numbers on discharge records that are not kept in confidential military medical files.

3. There has been an intermingling of an individual's general personnel records and his medical records at the National Personnel Record Center after his separation from service. The medical records have been made available for other than military uses after personnel have returned to civilian life. To protect confidential information we recommend an exploration of methods to separate from the personnel records the medical records and references to medical diagnoses.

We are pleased that the Department of Defense is already considering the problem of confidentiality, and we hope these comments will be of use in the implementation of its programs.

[1]The Task Force on Confidentiality as It Relates to Third Parties included: Maurice Grossman, M.D., chairman, Richard G. Johnson, M.D., Joseph Satten, M.D., Jack D. Barchas, M.D., and Alan L. Krueger, M.D.

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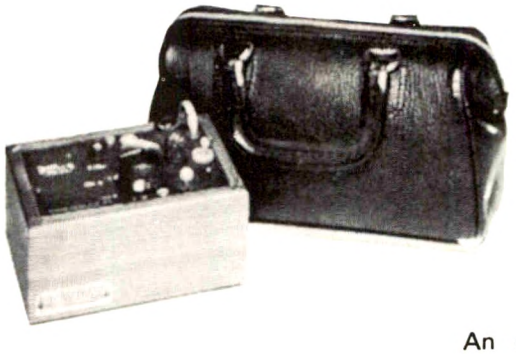
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Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In clinically significant depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD)

helps establish early therapeutic rapport

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of other tricyclic antidepressant poisoning.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK
SHARP
DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

Exploring the Nondrug Parameters of Tranquilizer Effectiveness No. 1

How individual patient variables influenc

It is now well established that certain nondrug factors can affect response to antianxiety medication. Thus, even with agents of proven efficacy, such as Librium (chlordiazepoxide HCl), different patients may exhibit varying degrees of symptomatic relief from excessive anxiety and tension.

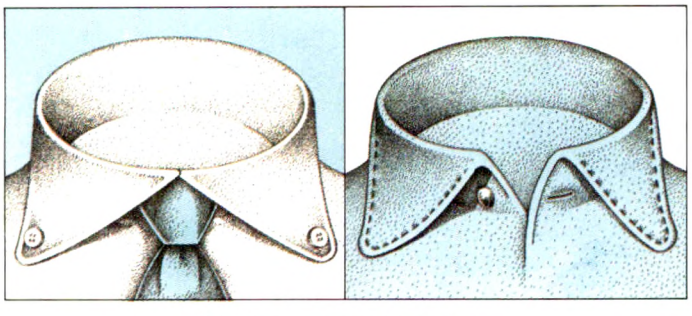
Apart from the effect of the physician's personality and prescribing attitudes on patient response,[1] there are certain significant patient variables, *e.g.*, personality type, severity and duration of anxiety, socioeconomic status, attitude toward medication and insight into the nature of the condition under treatment.[2-4] Thus, some clinical experience suggests that physically active extroverts, for whom abatement of anxiety may decrease the will to achieve or take action, may respond negatively – resulting in exacerbation of anxiety.[2] On the other hand, more passively anxious individuals with intellectual and esthetic inclinations have been shown to benefit from antianxiety medications.

When medication is indicated in the latter group, many psychiatrists place a high value on the benzodiazepines – of which Librium (chlordiazepoxide HCl) was the first in clinical use – for their antianxie effectiveness, broad usefulness and wide margin of safety.[2,3]

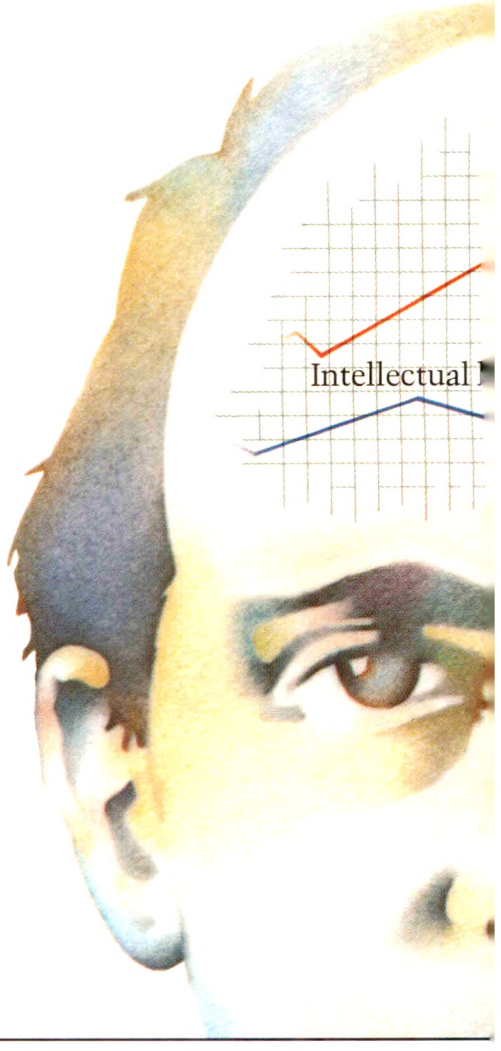
1. Rickels K, Lipman RS, Park LC, Covi L, Uhlenhuth EH, Mock JE: *Psychopharmacologia 20*:128-152, 1971
2. Hollister LE: *Ann Intern Med 79*:88-98, July 1973
3. Greenblatt DJ, Shader RI: *Ibid.*, 77: 91-100, July 1972
4. Rickels K, Downing RW, Howard K: *Clin Pharmacol Ther 12*:263-273, Mar-Apr 1971



Attitude to medication



Socioeconomic status



he effectiveness of antianxiety therapy

Demonstrated predictors of favorable response to Librium (chlordiazepoxide HCl)

In a double-blind, controlled study[4] of psychoneurotic patients with moderately severe anxiety, 111 patients were treated with Librium in a daily dosage of 30 to 40 mg, and 201 patients received a placebo. Outcome criteria included a global improvement measure after 2 and 4 weeks and the 4-week change score of a 10-item physician questionnaire.

Statistical analysis revealed that the greatest drug-placebo difference in relieving anxiety occurred among patients who were more severely ill, those in a higher socioeconomic class and those whose illness had persisted for at least six months. The more educated patient with high verbal ability, greater insight and an accepting attitude toward combined psychotherapy and drug therapy responded *significantly better* to Librium than to the placebo. On the other hand, patients of lower socioeconomic status, with less insight and greater readiness to accept medication alone as sufficient therapy, tend to show a moderately favorable response to both drug *and* placebo.

For proven effectiveness against excessive, obstructive anxiety

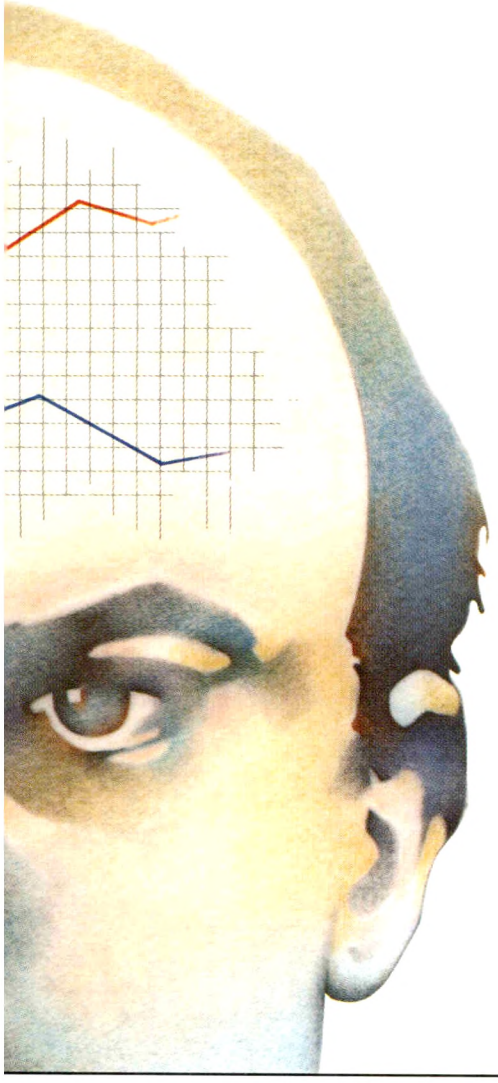
adjunctive

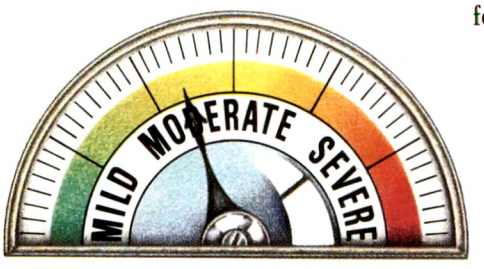
ROCHE **Librium®**

(chlordiazepoxide HCl)

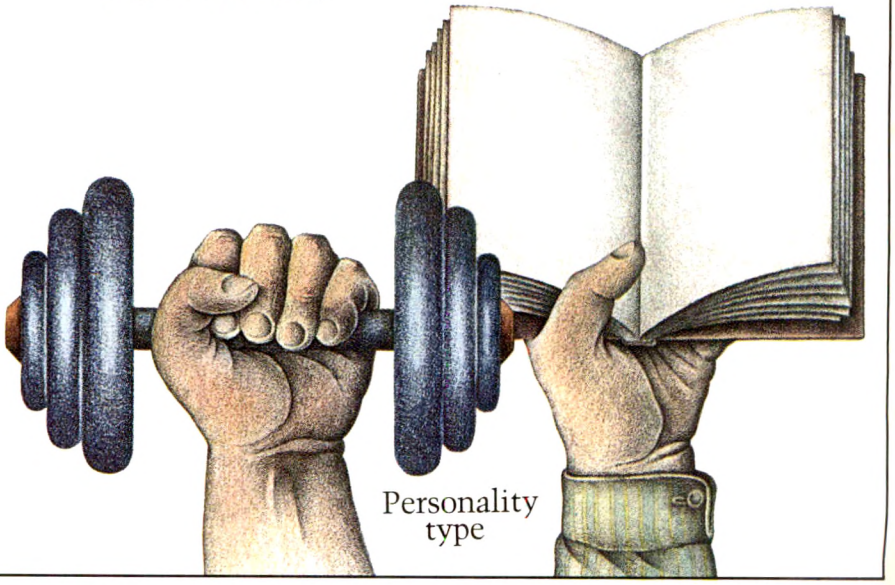
10 mg, 25 mg capsules

Please see following page for summary of product information.





Degree of anxiety



Personality type

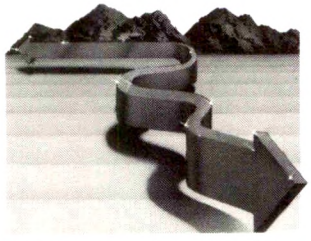
Effective adjunct in psychotherapy

Librium® (chlordiazepoxide HCl)

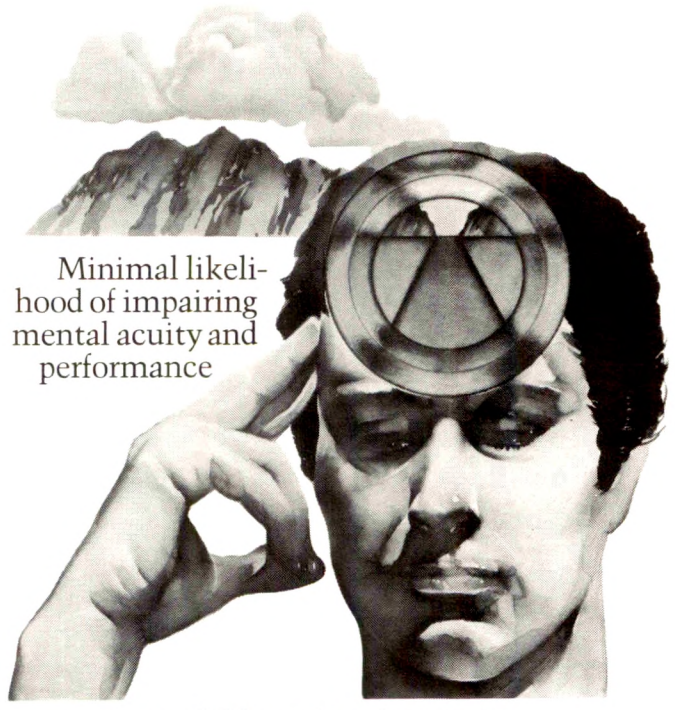
10 mg, 25 mg capsules/up to 100 mg daily in severe anxiety

While drowsiness, ataxia and confusion are the most frequently occurring side effects, physicians should be aware of the possibility of more serious reactions. Before prescribing, please consult complete product information, a summary of which appears below.

When anxiety has been reduced to useful, appropriate levels, Librium should be discontinued.



Wide margin of safety



Minimal likelihood of impairing mental acuity and performance

Dependable antianxiety action

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral– Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Agitated and hyperactive?



Consider the advantages of starting him on HALDOL® (haloperidol)

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HALDOL haloperidol appears to be particularly effective in calming mania and psychomotor agitation.[1-7] Symptom control is achieved rapidly, with many patients showing distinct improvement in a few days to a week[1,5]—frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[1,6,7]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL haloperidol is rare. In fact, this drug has been reported to increase activity in some underactive patients, while in hyperactive patients it usually reduces activity to a normal level without somnolence. HALDOL haloperidol has been found to "normalize" behavior and produce a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[8]

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HALDOL haloperidol, a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. The most commonly noted side effects of HALDOL haloperidol—extrapyramidal reactions—are usually dose-related and readily controlled with antiparkinson drugs.

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References: 1. Palestine, M.L., and Alatorre, E.: Quart. J. Stud. Alcohol 34:185 (Mar.) 1973. 2. Rees, L., and Davies, B.: Int. J. Neuropsychiat. 1:263 (June) 1965. 3. Sugerman, A.A., et al.: Amer. J. Psychiat. 120:1190 (June) 1964. 4. Rapp, M.S.: Canad. Psychiat. Ass. J. 15:73 (Feb.) 1970. 5. Towler, M.L., and Wick, P.H.: Int. J. Neuropsychiat. 3: Suppl. 1, 62 (Aug.) 1967. 6. Man, P.L., and Chen, C.H.: Psychosomatics 14:59 (Jan.-Feb.) 1973. 7. Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. 8. Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965.

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tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

*McNeil Laboratories, Inc., 1975

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An undetectable, tasteless liquid concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.



A rapid-acting injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Indications: HALDOL haloperidol is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome.

Contraindications: HALDOL haloperidol is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL haloperidol in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of haloperidol orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL haloperidol, decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL haloperidol may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL haloperidol should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL haloperidol may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant antiparkinson medication is required, it may have to be continued after HALDOL haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson agents, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of antiparkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long-term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed. 9/74

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The New Hampshire Hospital (the State's only psychiatric hospital) operates on the unit principle, each clinical geographic unit having close ties with the community mental health center(s) of its catchment area. There are special clinical units including Neurology, Child and Adolescent Care, Forensic, and Medically Infirm Care.

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A total of nine sessions per week will be undertaken.

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(a) The possession of the M.D. degree in Psychiatry of a recognized university or the M.R.C.P.I. in psychiatry or membership of the Royal College of Psychiatrists or the Diploma in Psychological Medicine awarded before February, 1972, or a professional qualification at least equivalent to one of these.
(b) At least seven years satisfactory experience (after full registration) in the practice of the medical profession including not less than five years satisfactory experience in psychiatry of which not less than three years was in child psychiatry.

Applications together with detailed Curriculum Vitae and the names and addresses of three references should be submitted to the Office of the Secretary/Manager, Mater Misericordiae Hospital, Dublin, 7, Republic of Ireland, as soon as possible.

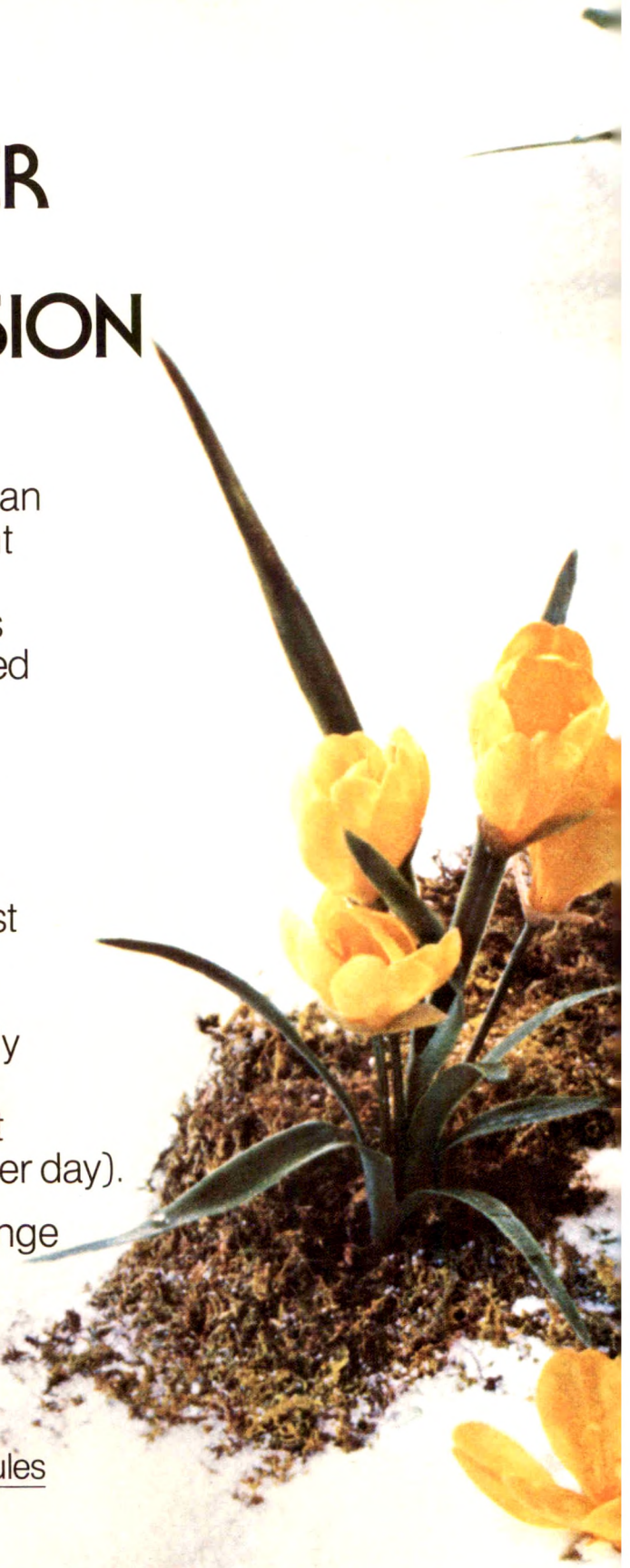
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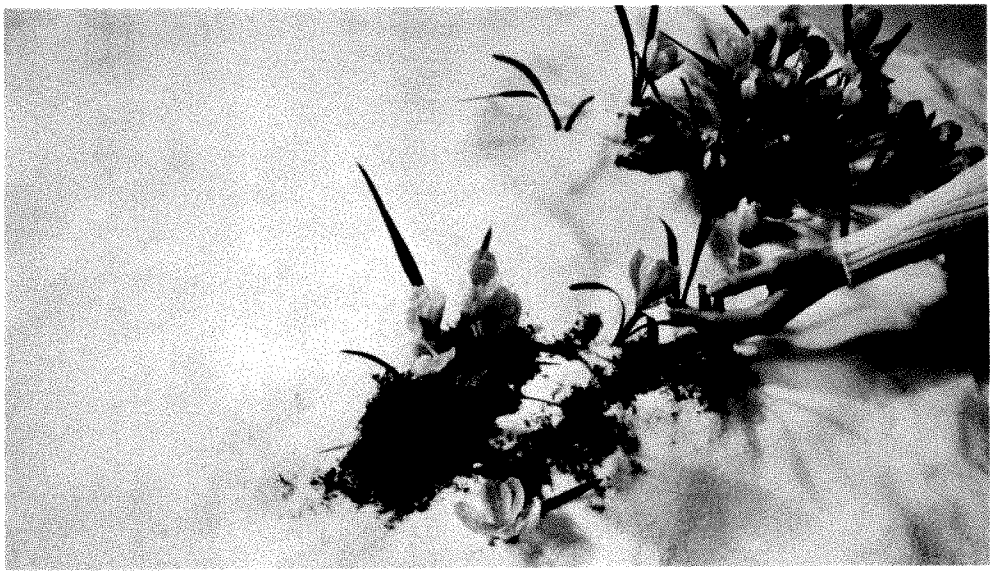
(See Brief Summary on following page for information on adverse reactions, contraindications, warnings and precautions.)

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A CHANGE FOR THE BETTER IN CLINICAL DEPRESSION



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BRIEF SUMMARY
Sinequan® (doxepin HCl) Capsules
Contraindications. Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's).

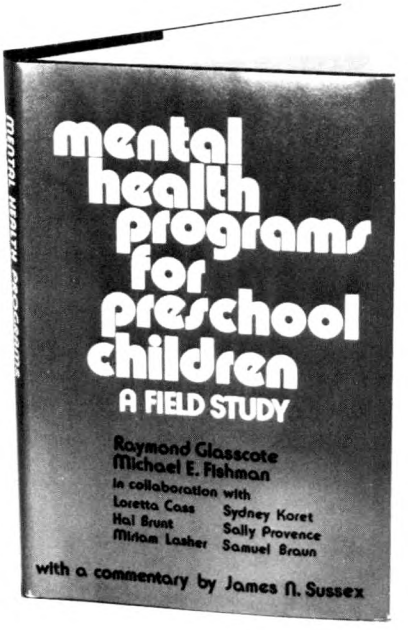
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This latest Joint Information Service field study provides a concise, comprehensive overview of the complex matter of the very young American child and his mental health, and then describes in intimate detail seven unique programs for pre-school children with problems—from North Hollywood's Dubnoff Center, emphasizing education as its primary therapeutic modality, to Baltimore's Martin Luther King, Jr. Parent-Child Center, serving two housing projects, served by Johns Hopkins, and largely governed by its own people. All different in treatment approach and philosophy, the programs described are uniform in their dedication to innovation in improving service to the emotionally disturbed very young child, and, equally, to the emotional well being of all young children.

This thoughtful and perceptive description of what has been created by some of the best informed, most experienced and thoughtful specialists in mental health services for very young children should be welcome to all involved in the mental health of children and a casebook for those dealing with child and family mental health.



An articulate exposition of the immense problems and encouraging accomplishments in a particularly difficult area of endeavor . . . . Beyond their concern with the manifestly ill child, the authors intriguingly explore what may be needed to enhance the mental good health of all young children . . . . A significant contribution.

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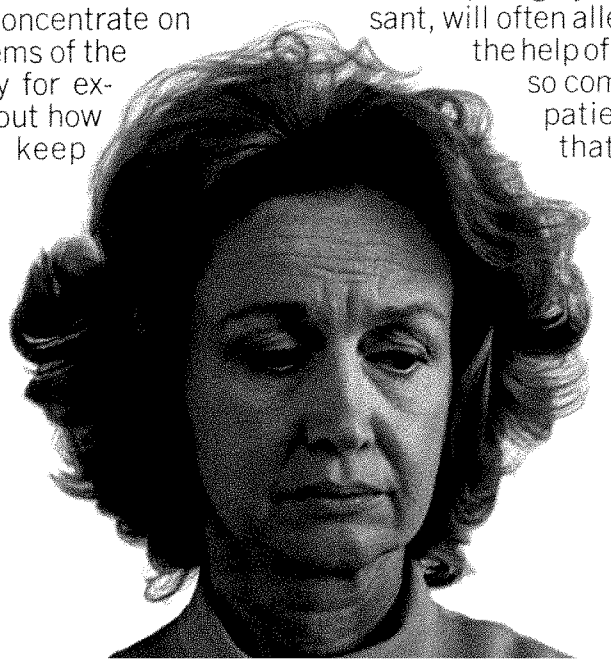
375AJP

in clinically significant depression...

penetrating the symptom barrier to productive psychotherapy

symptoms often interfere with therapy

In clinically significant depression, the patient often becomes barricaded behind his own symptoms during psychotherapy. Because these symptoms can be so sharply defined and somatic in expression, he may reject the fact that they are psychic in origin. Sleep disturbance, gastrointestinal complaints, anorexia, chronic fatigue, and other psychosomatic symptoms may so preoccupy—or overwhelm—the depressed patient that truly productive therapeutic sessions are difficult to achieve. Instead of being able to concentrate on the core emotional problems of the depression itself, he may for example go on at length about how broken his sleep is or keep reiterating (while the therapeutic hour slips by) how physically miserable he feels.



ELAVIL®
(AMITRIPTYLINE HCl, MSD)
to help penetrate the symptom barrier in depression requiring medication

ELAVIL, a highly effective tricyclic antidepressant, will often alleviate these symptoms. With the help of ELAVIL, sleep disturbance—so common in clinically depressed patients and often the symptom that distresses them most—as

well as other "barrier symptoms" may be lessened to the point where they no longer come between you and the patient.

psychotherapy takes direction

As these preoccupying complaints are lifted, psychotherapy sessions can become more productive. Patients are enabled to respond more fruitfully during therapeutic hours and to resume or pursue more efficiently the necessary activities in their personal lives.

meeting therapeutic goals

And as the antidepressant activity of ELAVIL (Amitriptyline HCl, MSD) takes hold, it helps relieve the depressive condition itself. Sometimes only a minimum of actual psychotherapy is required. The patient may experience a more rapid recovery—while you conserve valuable time.

Prescribe ELAVIL then, to help lighten the patient's burden in depression—and yours in its management.

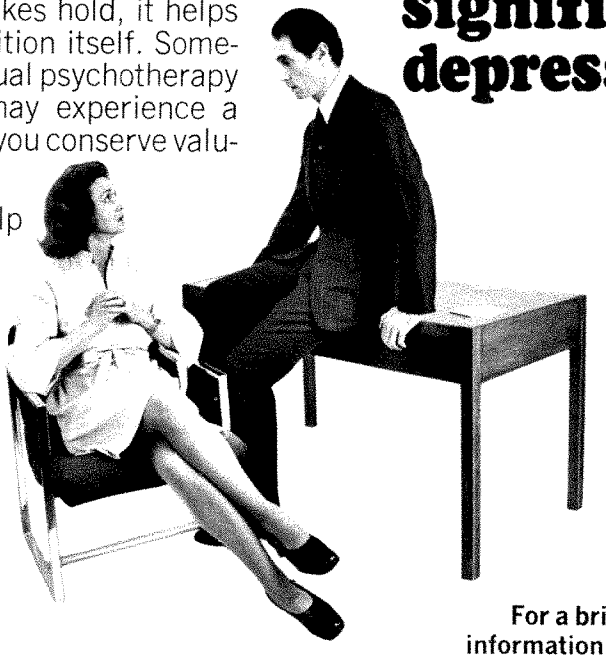
Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps increase your effectiveness in managing clinically significant depression



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For a brief summary of prescribing information, please see following page.

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addendum

In adult outpatients
with clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

once a day AT BEDTIME or **divided dosage** DAILY

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.
When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

ELAVIL
(AMITRIPTYLINE HCl, MSD)

MSD
MERCK SHARP & DOHME

THE NATION'S PSYCHIATRISTS— 1970 SURVEY

prepared by

Franklyn N. Arnhoff, Ph.D.

and

A. H. Kumbar

In this report, the survey data are organized under five general categories.

1. **Supply Characteristics** describes the survey sample in terms of its total number and the percent of response, APA members as well as the number who were in training and those psychiatrists with less than three years' training. It gives data on their age, sex, citizenship, race and work status.
2. **The Education and Training of Psychiatrists** provides data on the number in the sample who graduated from various medical schools by year, the number of years in training, whether the respondent is board certified, etc. All data are analyzed by sex so that this important dimension can be evaluated directly. Data on country of origin of medical school attended are also given for foreign medical graduates.
3. **Professional Activities of Psychiatrists** presents analyses dealing with various aspects of professional practice: where psychiatrists spend their time, how time is allocated, and what they do.
4. **Geographic Distribution of Psychiatrists** presents state totals for the identified manpower pool, along with ratios per 100,000 population.
5. **The Economic Issues** looks at such issues as the source of professional income and hours donated.

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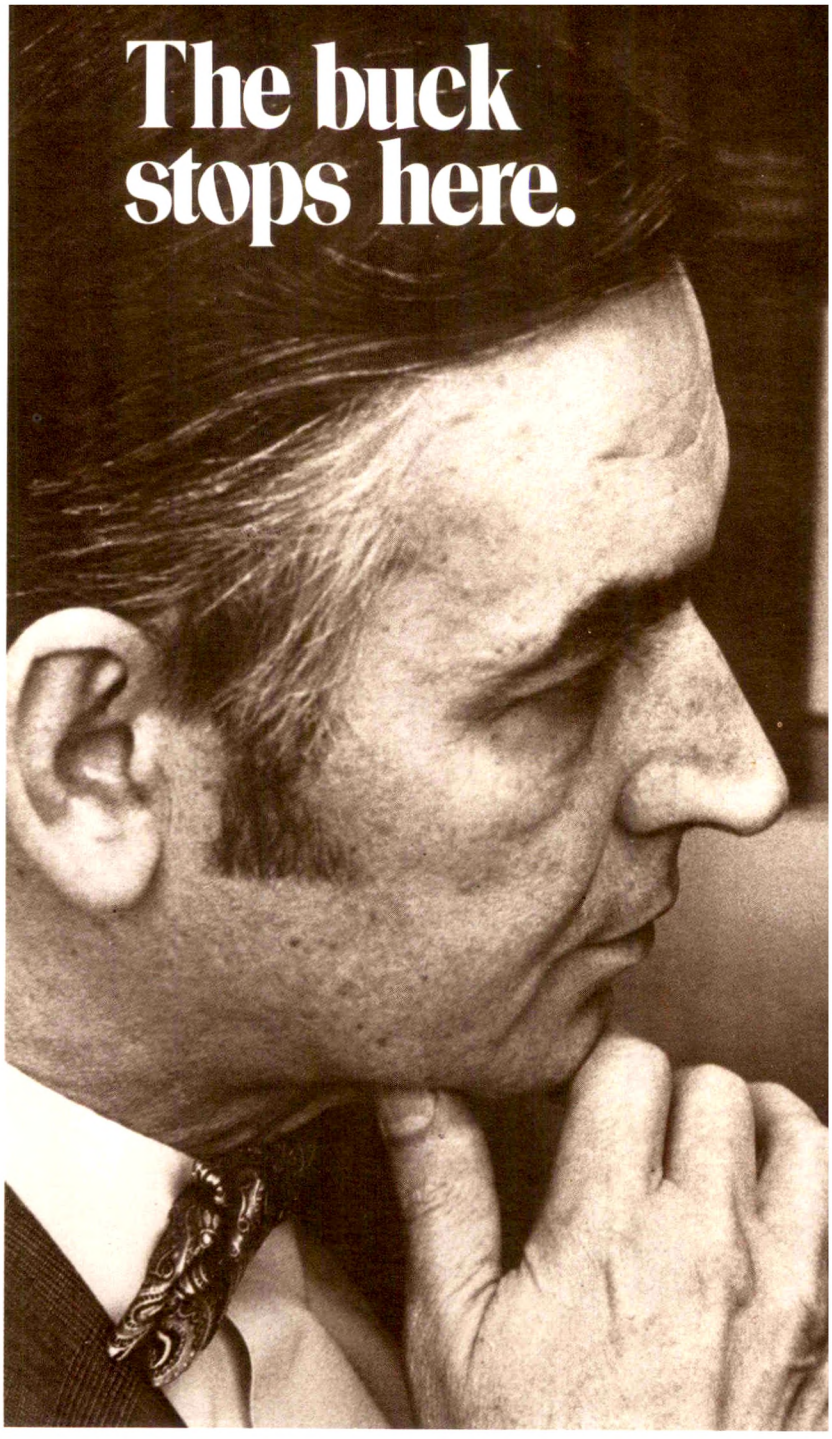
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Indication: For relief of mental depression. **Contraindications:** Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane (desipramine HCl) in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine. **Dosage:** All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink), bottles of 100 and 1000. Also, 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.



How often are you the last resort?

How best to encourage a productiv one-to-one relationship for treatment of this most difficult emotional problem?
Establishing rapport with the depressed patient is basic to building patient confidence for productive psychotherapy. Pertofrane (desipramine HCl) can be a helpful adjunct to your therapy particularly in the early stages, to help relieve depressive symptoms As the depression lifts, new pathways that permit enhanced cooperation for more effective psychotherapy are opened.

Please read brief summary of prescribing information.



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pecific for Depression

om the report[1] of a clinical trial desipramine in 105 depressed vate patients. Usual dosage—
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here was a clearly parallel provement in sleep when pression improved and a lack of s improvement when depression s sustained."

a preliminary study[2] of sipramine in 30 private-practice tients with depressive illnesses. ual dosage—75 to 150 mg. per y, plus psychotherapy and nquilizers as needed.

"In many instances hospitalization was avoided because of the drug's [desipramine] rapid action, and patients were able to function adequately on their jobs or at home throughout the treatment period."

"[Desipramine] exerted a faster onset of action... compared to previous use of imipramine."

1. Marshall, M.H.: Psychopharmacology of Depression: Perspectives in Research, Psychosomatics 12:49, 1971.
2. Barringer, T.J.: Clinical Trial of Desipramine in the Treatment of Depression, Am. J. Psychiatry 121:1117, 1965.

Pertofrane®
(desipramine hydrochloride NF)
Specific for Depression

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USV PHARMACEUTICAL MFG. CORP.
Manati, P.R. 00701


May enhance other remedial efforts in treating MBD[1]
ONLY WHEN MEDICATION IS INDICATED
Ritalin®
(methylphenidate)

Ritalin...of proven value when used as part of a complete therapeutic and remedial MBD program

More than a decade of clinical experience shows that Ritalin helps improve ratings of behavior, attentiveness, performance IQ, motor control, and speech productivity in children with Minimal Brain Dysfunction (MBD).[1-5]

Currently a drug of choice in many MBD situations,[6] Ritalin can play an important part in the total rehabilitation program of the MBD child. And proper management is essential to the overall (educational, social, and emotional) development of the child's potential.

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. Often, these interruptions reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and eventual discontinuance of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.



References
1. Knobel M: *Arch Gen Psychiatry* **6**:198-202, 1962.
2. Knights RM, Hinton GG: *J Nerv Ment Dis* **148**:643-653, 1969.
3. Creager RO, VanRiper C: *J Speech Hear Res* **10**:623-628, 1967.
4. Werry JS: Paper presented at the Annual Meeting of the American Psychiatric Association, Boston, May 13-17, 1968.
5. Conners CK: *Pediatrics* **49**:702-708, 1972.
6. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.

Ritalin® hydrochloride
(methylphenidate hydrochloride)
TABLETS

INDICATION
Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)
Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.
Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.
CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.
WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC, differential, and platelet counts are advised during prolonged therapy.
ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.
DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.
HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

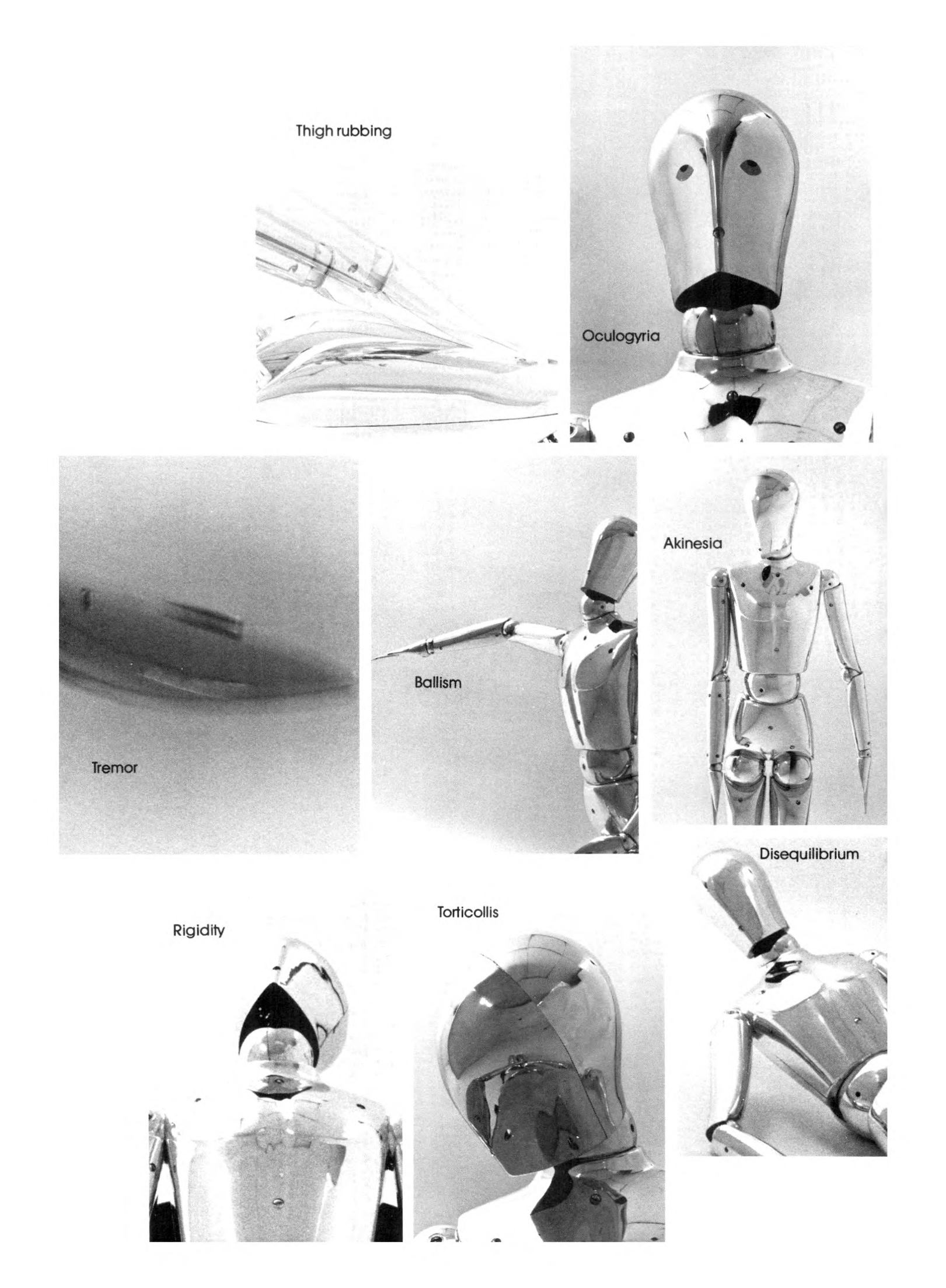
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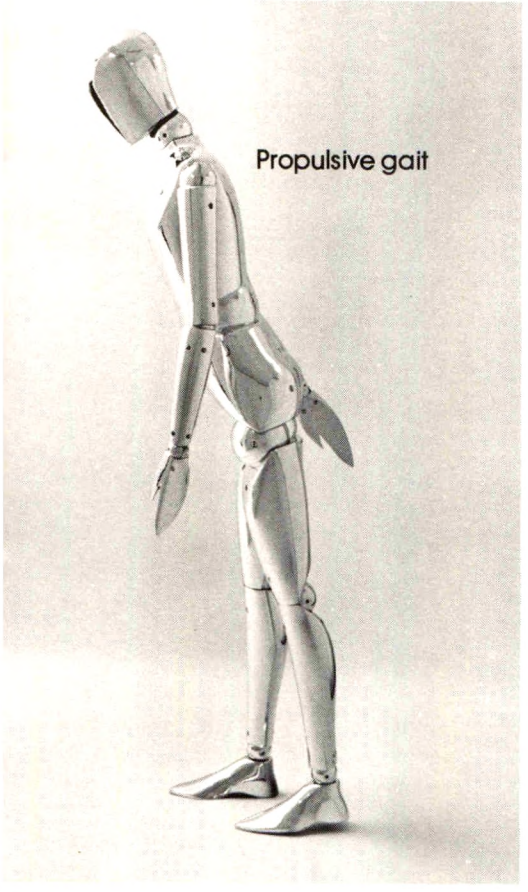
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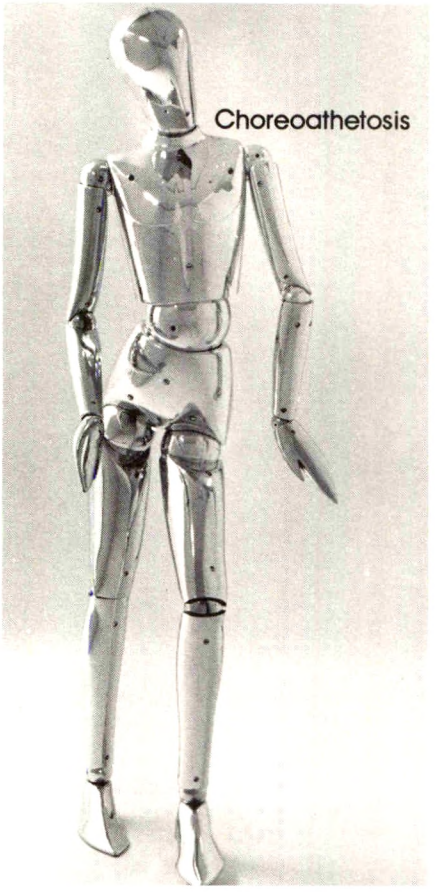
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■ ARTANE® Trihexyphenidyl HCl. It can prevent or reverse the sometime dehumanizing extrapyramidal effects of the antipsychotic drugs. ■ But without the drug buildup potential of cumulative action anticholinergics. ■ And at lower cost.

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Tablets and Elixir: Indications: FDA has evaluated this drug as Effective as an adjunct in the therapy of the indications listed below under SEQUELS.

***INDICATIONS FOR ARTANE SEQUELS:**
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms of parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for the use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine and phenothiazines.

WARNING:
Patients to be treated should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated. Periodic gonioscopic evaluations in all patients to be treated with this or any related drug is advised.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilatation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache. Angle-closure glaucoma due to long-term treatment with this drug has been reported.

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VALIUM®
(diazepam)
IN THE CONTEXT OF PSYCHOTHERAPY FOR PSYCHONEUROTIC DISORDERS



When predominant anxiety is associated with depressive symptoms in the psychoneurotic patient, the effects may be incapacitating. Feelings of self-esteem seem threatened, and the patient is particularly vulnerable to psychophysiological symptoms affecting the heart, stomach, colon or respiratory tract. Her condition may even interfere with her response to various psychotherapeutic measures. Until the excessive anxiety and its attendant symptoms are relieved, the patient may feel so insecure that she is unable to function.

Often, the patient can't cope with her symptoms while she "works things out"

You may decide that the psychoneurotic patient can benefit from group therapy sessions. However, many patients are uneasy about joining a group, and in the beginning your reassurance and understanding alone may not be enough to help the overly anxious patient face the group. Even though she realizes that she will eventually work through some of the underlying problems, she is experiencing distressing symptomatology that requires more immediate relief. You frequently hear, "What do I do in the meantime, doctor?"



Valium (diazepam) as an adjunct to group therapy—it may have an important role

During psychotherapy for psychoneurotic disorders, Valium offers relief of predominant anxiety and reduces the depressive symptoms often associated with it. The patient generally starts to benefit as early as the first day of therapy, and significant improvement is usually evident within the first few days. Valium is provided in several dosage strengths, so you can precisely control the medication to suit your patient's needs and preclude oversedation or ataxia. If the patient remains symptomatic at bedtime, an *h.s.* dose added to a 2- to 10-mg *b.i.d.* or *t.i.d.* regimen is often very effective. Valium is generally well tolerated and in recommended dosages rarely produces significant untoward reactions, but patients should be cautioned about potentially hazardous activities requiring complete mental alertness, such as driving.

VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets

can reduce predominant anxiety and its associated depressive symptoms

ROCHE

Please see following page for a summary of product information.

VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 100.

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March 1975

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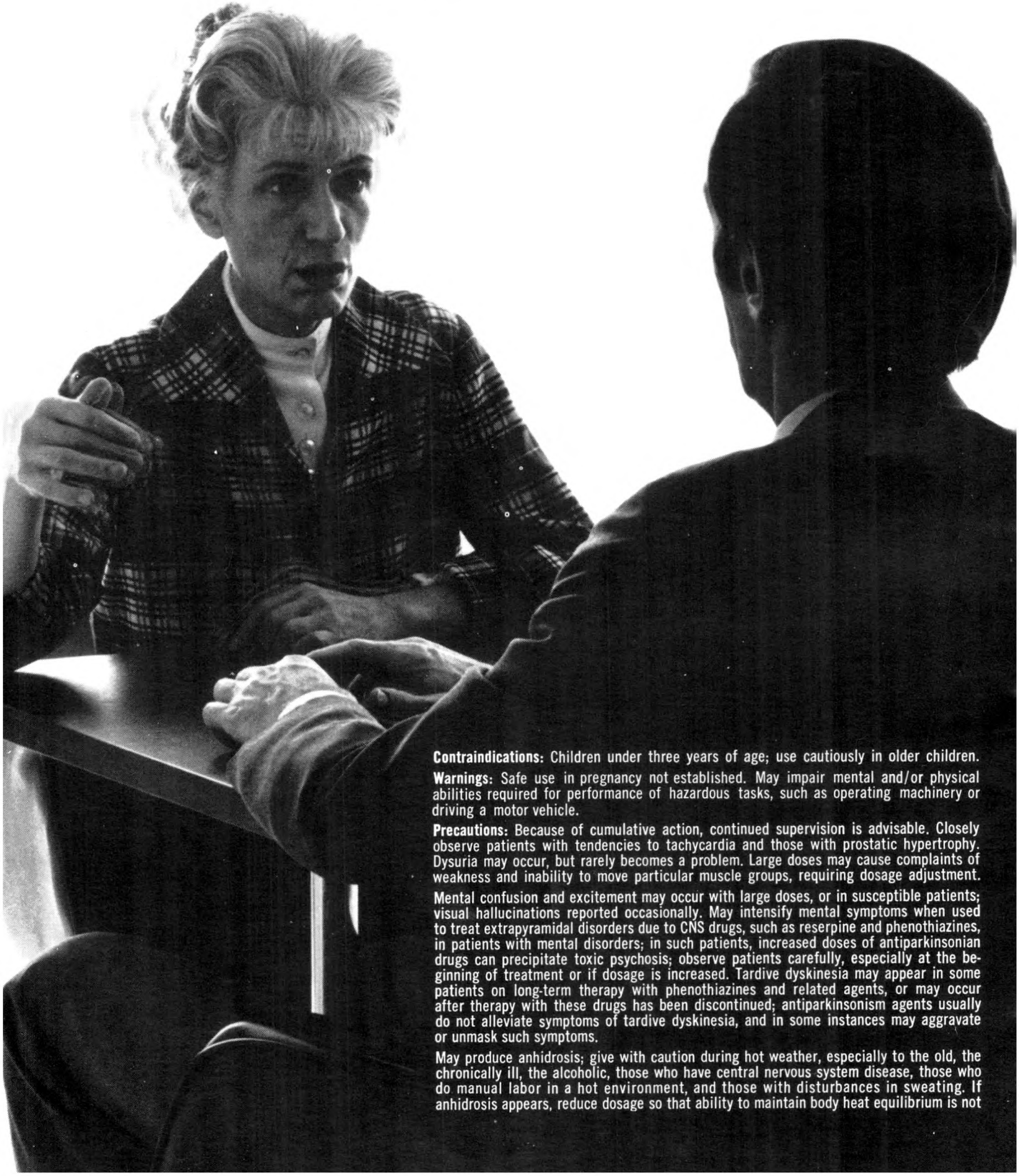
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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

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helps alleviate most phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; Injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

MSD
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addendum

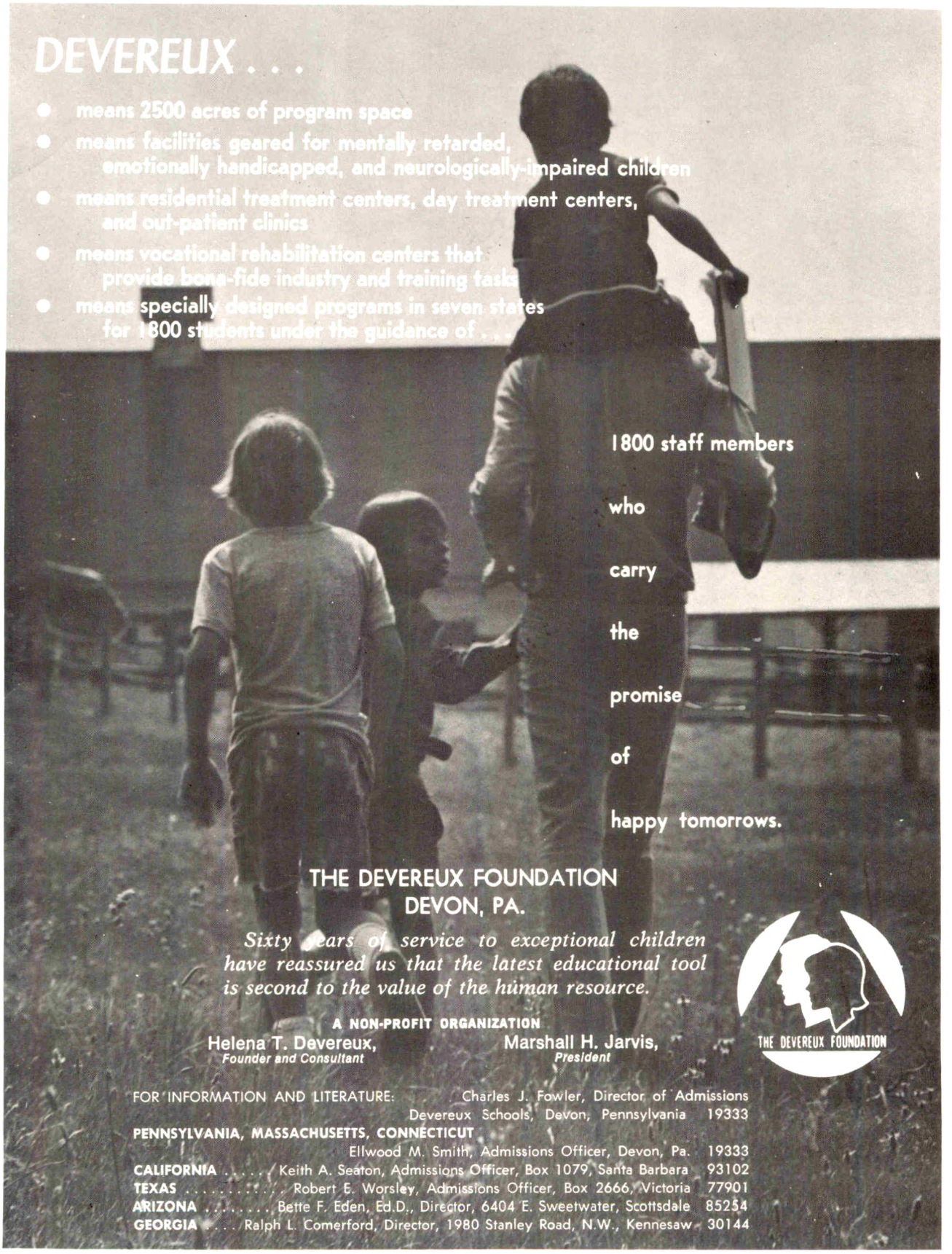
Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

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For more detailed information, see full prescribing information.


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Schizophrenic patients sometimes hide behind a mask of psychotic withdrawal, which can make them inaccessible to therapy. Effective management of such patients often begins with 'Stelazine':

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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, pancytopenia, anemia, cholestatic jaundice, liver damage have been reported.

Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema, reversed epinephrine effect; hyperpyrexia; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

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Religion and Psychiatry . . . ABRAHAM N. FRANZBLAU
The Right to Treatment . . . JONAS R. RAPPEPORT

THE NATION'S PSYCHIATRISTS— 1970 SURVEY

prepared by

Franklyn N. Arnhoff, Ph.D.

and

A. H. Kumbar

In this report, the survey data are organized under five general categories.

1. **Supply Characteristics** describes the survey sample in terms of its total number and the percent of response, APA members as well as the number who were in training and those psychiatrists with less than three years' training. It gives data on their age, sex, citizenship, race and work status.
2. **The Education and Training of Psychiatrists** provides data on the number in the sample who graduated from various medical schools by year, the number of years in training, whether the respondent is board certified, etc. All data are analyzed by sex so that this important dimension can be evaluated directly. Data on country of origin of medical school attended are also given for foreign medical graduates.
3. **Professional Activities of Psychiatrists** presents analyses dealing with various aspects of professional practice: where psychiatrists spend their time, how time is allocated, and what they do.
4. **Geographic Distribution of Psychiatrists** presents state totals for the identified manpower pool, along with ratios per 100,000 population.
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In depression: One capsule lasts from bedtime to bedtime.

For single-dose therapy in depression when the dosage is established.

- simple enough dosage regimen to help avoid missed doses.
- provides a full range of single daily dosage strengths, including the 75- and 150-mg. capsules.*
- as effective as divided daily doses.
- the 150-mg. capsule may be the most effective daily dose for many patients.
- saves time and cost of dosage administration in the hospital.

Please read the prescribing information for details of usage, precautions, warnings, contraindications, adverse experiences, and dosage recommendations. A summary of this information appears on the back of this page.

*Also available in capsules of 100 and 125 mg. Each capsule contains imipramine pamoate equivalent to 150, 125, 100 or 75 mg. of imipramine hydrochloride.

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Capsules* of 150, 125, 100 and 75 mg.

In depression: One capsule lasts from bedtime to bedtime.

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brand of imipramine pamoate
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brand of imipramine hydrochloride USP

Indications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil, brand of imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

- —patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- —patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- —hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- —patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- —patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, Tofranil, brand of imipramine hydrochloride, is not recommended for treatment of depression in patients under twelve years of age.

Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil, brand of imipramine hydrochloride, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil, brand of imipramine hydrochloride, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations; disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. Dosage should be initiated with Tofranil, brand of imipramine hydrochloride, at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission.

Once-a-day maintenance dosage can be provided with Tofranil-PM, brand of imipramine pamoate, capsules if this dosage has been established as explained above. This dose may be given at bedtime. For the occasional patient who manifests stimulation and insomnia with this dosage regimen, the capsules may be given in the morning.

Parenteral administration should be used only for starting therapy in patients unable or unwilling to use oral medication. The oral form should supplant the injectable as soon as possible.

How Supplied: Tofranil, brand of imipramine hydrochloride: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg.; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-850-P (2/74)

For complete details, including dosage and administration, please refer to the full prescribing information.

GEIGY Pharmaceuticals
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Ardsley, New York 10502

*Each capsule contains imipramine pamoate equivalent to 150, 125, 100 or 75 mg. of imipramine hydrochloride.

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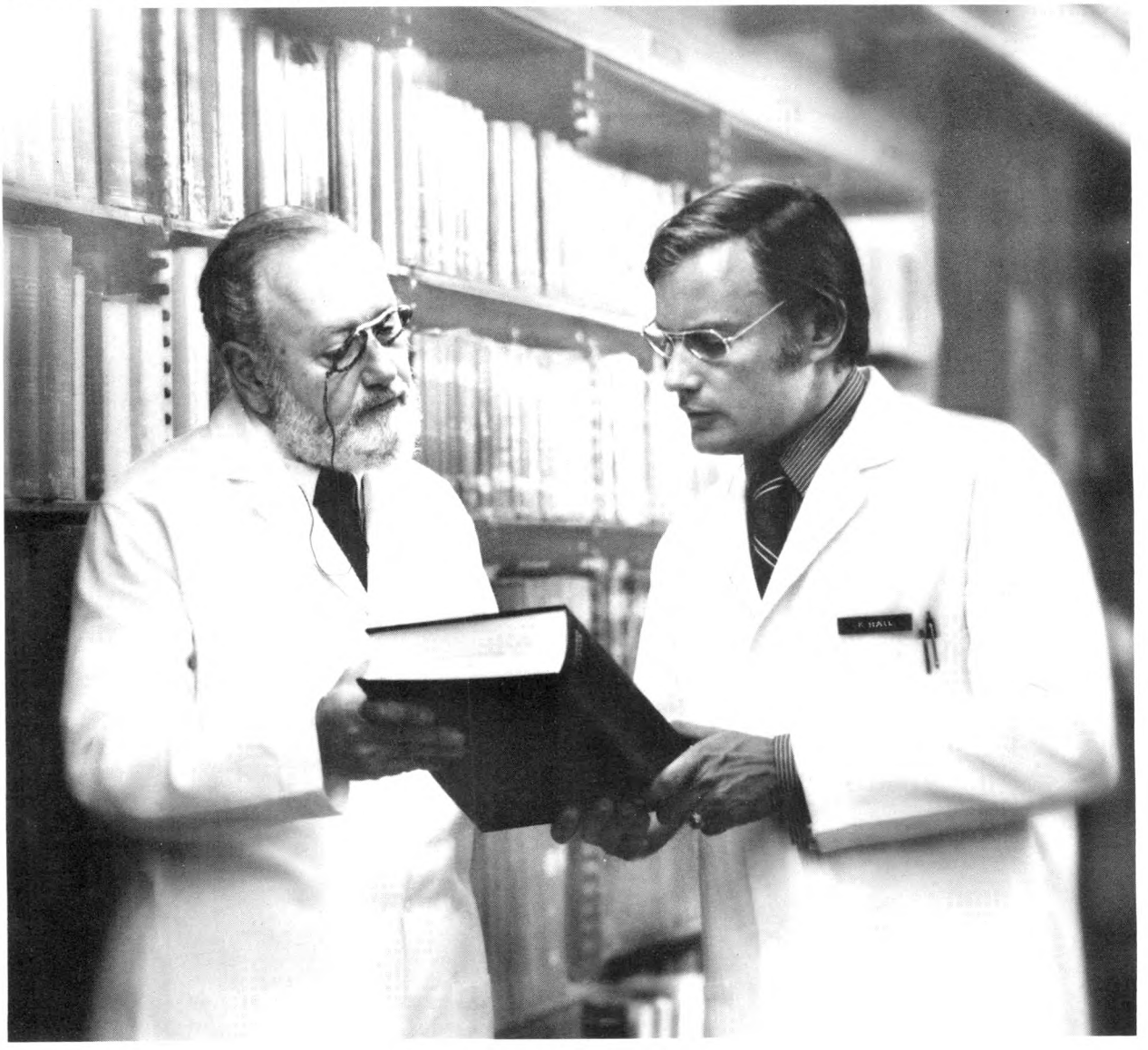
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"Insomnia often occurs when a patient is troubled by a problem for which he is not prepared."

Passing on a valid point:
a sense of continuity from one generation of psychiatrists to another.



Insomnia is a problem for which NOLUDAR® 300 (methyprylon) Ⓒ III is prepared

Effectiveness. A single capsule of Noludar 300 generally provides an uninterrupted night's sleep of from 5 to 8 hours duration. Sleep is usually induced within 45 minutes.

Safety. While Noludar 300 is a Schedule III controlled medication, it is not a barbiturate or a methaqualone. Administer with caution to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative.

Reliability. Noludar is a reliable hypnotic in use for over 19 years. It can help the insomniac patient sleep and wake refreshed to meet the new day, usually with little or no morning-after "hang-over." At recommended dosages (one capsule before retiring), paradoxical excitation has been rare.

Before prescribing, please consult Complete Product Information, a summary of which follows:

INDICATION: As a hypnotic for relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence have been reported infrequently. Withdrawal symptoms, when they occur, tend to resemble those associated with withdrawal of barbiturates and should be treated in a similar fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be limited without adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

Usage in Children: Not recommended in children under 3 months of age.

PRECAUTIONS: Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits. Observe usual precautions in hepatic or renal disorders. Perform periodic blood counts if used repeatedly or over prolonged periods.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few, isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

SUPPLIED: *Capsules* containing 300 mg methyprylon. *Tablets* containing 200 mg or 50 mg methyprylon.

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ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

in clinically significant depression...

penetrating the symptom barrier to productive psychotherapy

symptoms often interfere with therapy

In clinically significant depression, the patient often becomes barricaded behind his own symptoms during psychotherapy. Because these symptoms can be so sharply defined and somatic in expression, he may reject the fact that they are psychic in origin. Sleep disturbance, gastrointestinal complaints, anorexia, chronic fatigue, and other psychosomatic symptoms may so preoccupy—or overwhelm—the depressed patient that truly productive therapeutic sessions are difficult to achieve. Instead of being able to concentrate on the core emotional problems of the depression itself, he may for example go on at length about how broken his sleep is or keep reiterating (while the therapeutic hour slips by) how physically miserable he feels.

ELAVIL®
(AMITRIPTYLINE HCl, MSD)
to help penetrate the symptom barrier in depression requiring medication

ELAVIL, a highly effective tricyclic antidepressant, will often alleviate these symptoms. With the help of ELAVIL, sleep disturbance—so common in clinically depressed patients and often the symptom that distresses them most—as



well as other "barrier symptoms" may be lessened to the point where they no longer come between you and the patient.

psychotherapy takes direction

As these preoccupying complaints are lifted, psychotherapy sessions can become more productive. Patients are enabled to respond more fruitfully during therapeutic hours and to resume or pursue more efficiently the necessary activities in their personal lives.

meeting therapeutic goals

And as the antidepressant activity of ELAVIL (Amitriptyline HCl, MSD) takes hold, it helps relieve the depressive condition itself. Sometimes only a minimum of actual psychotherapy is required. The patient may experience a more rapid recovery—while you conserve valuable time.

Prescribe ELAVIL then, to help lighten the patient's burden in depression—and yours in its management.

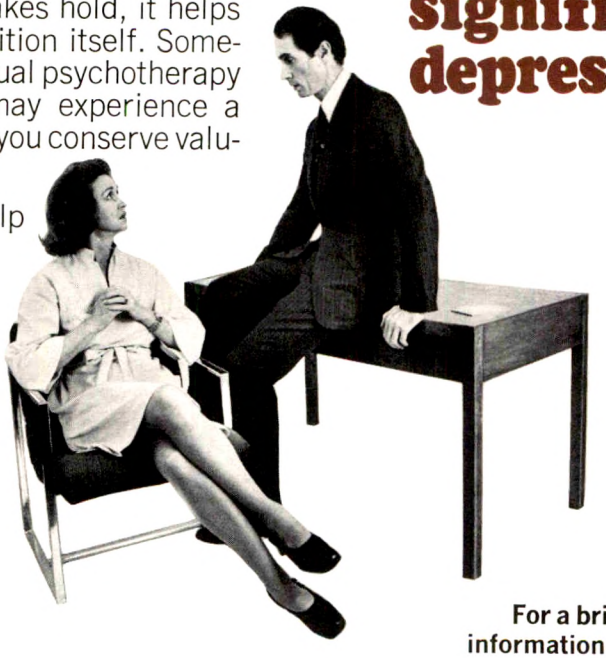
Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps increase your effectiveness in managing clinically significant depression



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For a brief summary of prescribing information, please see following page.

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addendum

In adult outpatients with clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

once a day AT BEDTIME | or | **divided dosage** DAILY

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.
When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

ELAVIL
(AMITRIPTYLINE HCl, MSD)

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- Frank J. Ayd, Jr., on
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Suspicious and hostile?



Consider the advantages of starting her on HALDOL® (haloperidol)

Acts promptly to control hostility and suspiciousness

Several clinicians have cited the special value of HALDOL haloperidol in controlling hostility, suspiciousness, ideas of persecution and other delusions associated with psychoses.[1-6] Symptom control is achieved rapidly, with many patients showing distinct improvement in a few days to a week[1,6]—frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[7,8]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL haloperidol is rare. In fact, this drug has been reported to increase activity in some underactive patients, while in hyperactive patients it usually reduces activity to a normal level without somnolence. HALDOL haloperidol has been found to "normalize" behavior and produce a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[4]

Reduces likelihood of certain adverse reactions

HALDOL haloperidol, a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. The most commonly noted side effects of HALDOL haloperidol—extrapyramidal reactions—are usually dose-related and readily controlled with antiparkinson drugs.

Transient hypotension occurs rarely; severe orthostatic hypotension has not been reported. HALDOL haloperidol is also unlikely to cause hepatic damage, serious hematologic reactions, photosensitivity reactions and skin rashes. Ocular damage and pigmentation changes have not been reported.

References: 1. Towler, M.L., and Wick, P.H.: Int. J. Neuropsychiat. 3: Suppl. 1,62 (Aug.) 1967. 2. Crane, G.E.: Int. J. Neuropsychiat. 3: Suppl. 1,111 (Aug.) 1967. 3. Ban, T.A., and Lehmann, H.E.: Int. J. Neuropsychiat. 3: Suppl. 1,79 (Aug.) 1967. 4. Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965. 5. Yun, B.S., et al.: Mich. Med. 67:1349 (Nov.) 1968. 6. Rubin, R.: Alabama J. Med. Sci. 8:414 (Oct.) 1971. 7. Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. 8. Palestine, M.L., and Alatorre, E.: Quart. J. Stud. Alcohol 34:185 (Mar.) 1973.

HALDOL®
(haloperidol)
tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

*McNeil Laboratories, Inc., 1975

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(haloperidol)
tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

A Dosage Form for Every Need:



5 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg., 5 mg. and 10 mg.



An undetectable, tasteless liquid concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.



A rapid-acting injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Indications: HALDOL haloperidol is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome.

Contraindications: HALDOL haloperidol is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL haloperidol in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of haloperidol orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL haloperidol, decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL haloperidol may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL haloperidol should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL haloperidol may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant antiparkinson medication is required, it may have to be continued after HALDOL haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson agents, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of antiparkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long-term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed. 9/74

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Exploring the Nondrug Parameters of Tranquilizer Effectiveness No. 1

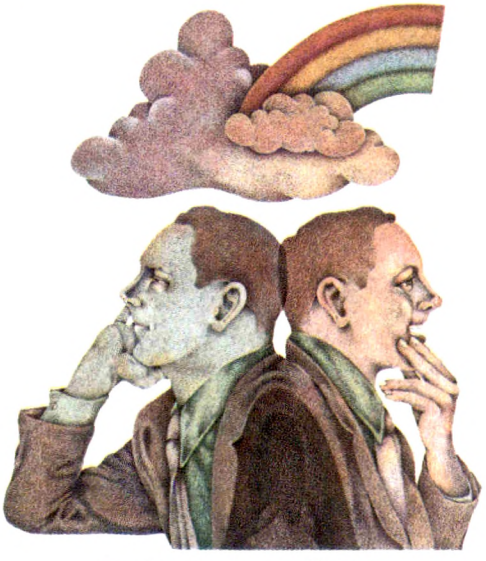
How individual patient variables influence

It is now well established that certain nondrug factors can affect response to antianxiety medication. Thus, even with agents of proven efficacy, such as Librium (chlordiazepoxide HCl), different patients may exhibit varying degrees of symptomatic relief from excessive anxiety and tension.

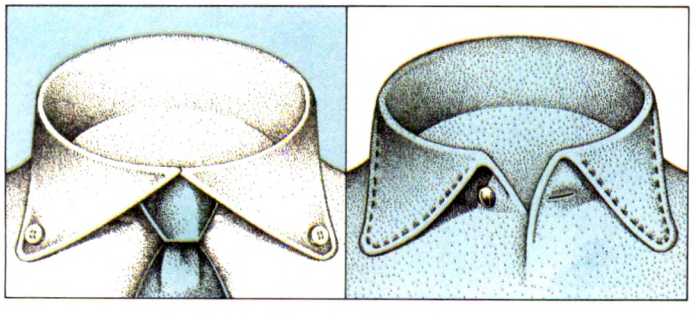
Apart from the effect of the physician's personality and prescribing attitudes on patient response,[1] there are certain significant patient variables, *e.g.*, personality type, severity and duration of anxiety, socioeconomic status, attitude toward medication and insight into the nature of the condition under treatment.[2-4] Thus, some clinical experience suggests that physically active extroverts, for whom abatement of anxiety may decrease the will to achieve or take action, may respond negatively – resulting in exacerbation of anxiety.[2] On the other hand, more passively anxious individuals with intellectual and esthetic inclinations have been shown to benefit from antianxiety medications.

When medication is indicated in the latter group, many psychiatrists place a high value on the benzodiazepines – of which Librium (chlordiazepoxide HCl) was the first in clinical use – for their antianxiety effectiveness, broad usefulness and wide margin of safety.[2,3]

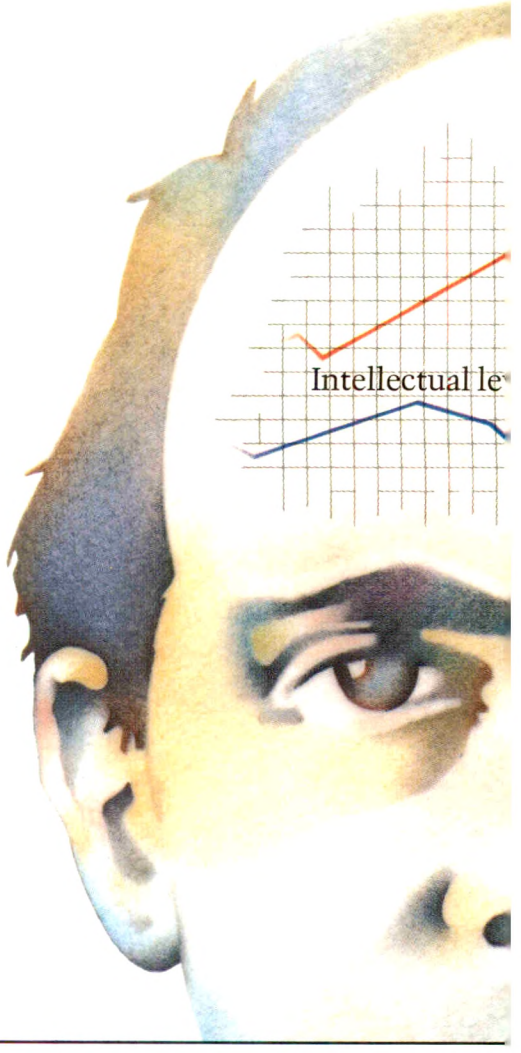
1. Rickels K, Lipman RS, Park LC, Covi L, Uhlenhuth EH, Mock JE: *Psychopharmacologia 20*:128-152, 1971
2. Hollister LE: *Ann Intern Med* 79:88-98, July 1973
3. Greenblatt DJ, Shader RI: *Ibid.*, 77: 91-100, July 1972
4. Rickels K, Downing RW, Howard K: *Clin Pharmacol Ther 12*:263-273, Mar-Apr 1971



Attitude to medication



Socioeconomic status



the effectiveness of antianxiety therapy

Demonstrated predictors of favorable response to Librium (chlordiazepoxide HCl)

In a double-blind, controlled study[4] of psychoneurotic patients with moderately severe anxiety, 111 patients were treated with Librium in a daily dosage of 30 to 40 mg, and 201 patients received a placebo. Outcome criteria included a global improvement measure after 2 and 4 weeks and the 4-week change score of a 10-item physician questionnaire.

Statistical analysis revealed that the greatest drug-placebo difference in relieving anxiety occurred among patients who were more severely ill, those in a higher socioeconomic class and those whose illness had persisted for at least six months. The more educated patient with high verbal ability, greater insight and an accepting attitude toward combined psychotherapy and drug therapy responded *significantly better* to Librium than to the placebo. On the other hand, patients of lower socioeconomic status, with less insight and greater readiness to accept medication alone as sufficient therapy, tend to show a moderately favorable response to both drug *and* placebo.

For proven effectiveness against excessive, obstructive anxiety

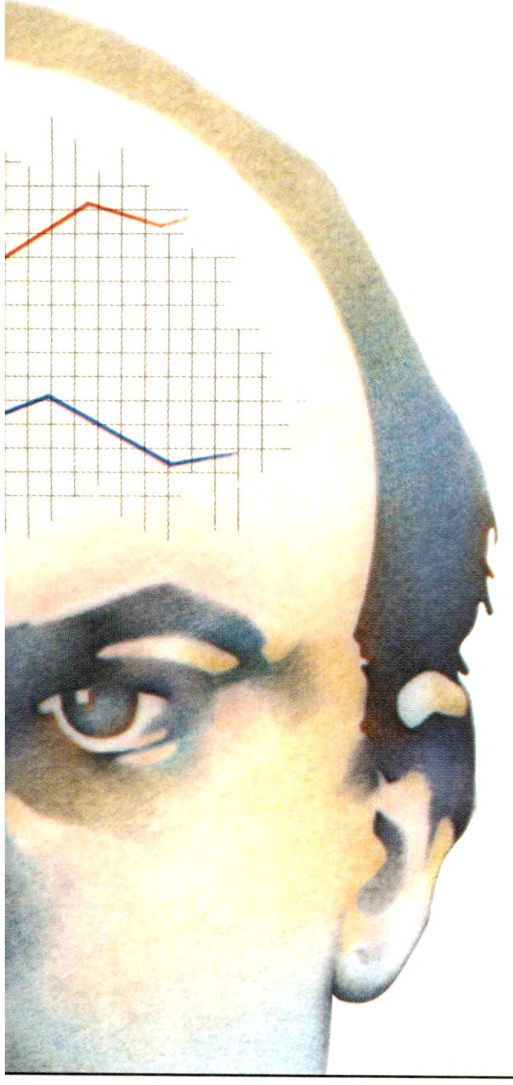
adjunctive

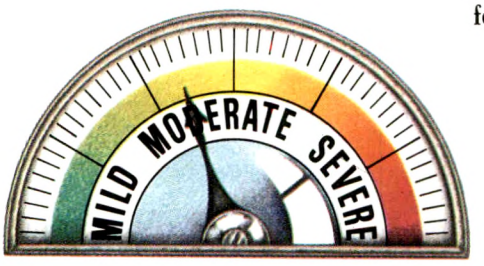
ROCHE **Librium®**

(chlordiazepoxide HCl)

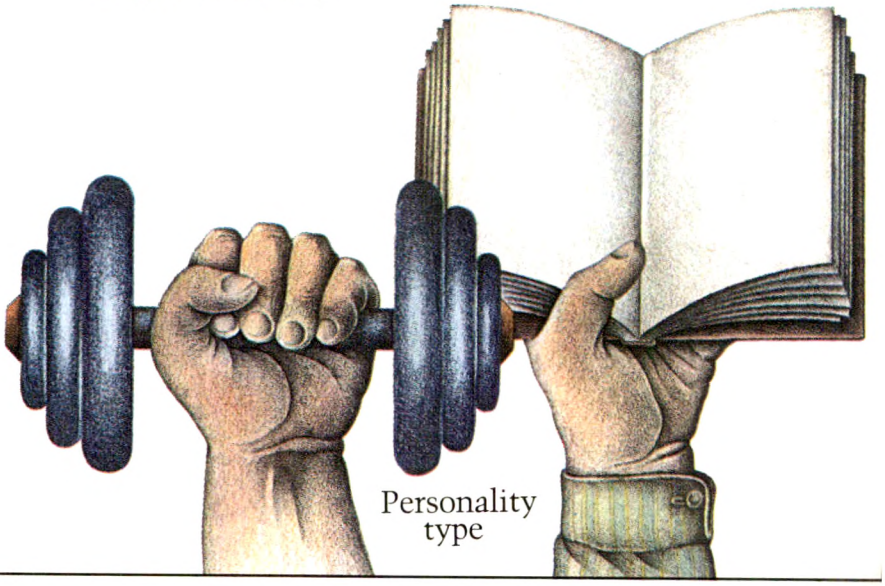
10 mg, 25 mg capsules

Please see following page for summary of product information.





Degree of anxiety



Personality type

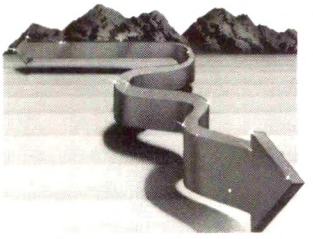
Effective adjunct in psychotherapy

Librium® (chlordiazepoxide HCl)

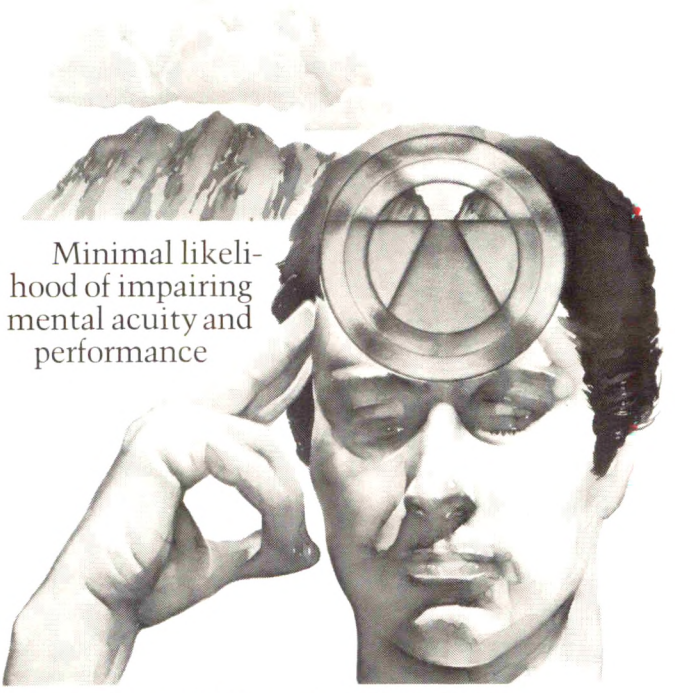
10 mg, 25 mg capsules/up to 100 mg daily in severe anxiety

While drowsiness, ataxia and confusion are the most frequently occurring side effects, physicians should be aware of the possibility of more serious reactions. Before prescribing, please consult complete product information, a summary of which appears below.

When anxiety has been reduced to useful, appropriate levels, Librium should be discontinued.



Wide margin of safety



Minimal likelihood of impairing mental acuity and performance

Dependable antianxiety action

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral— Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg – bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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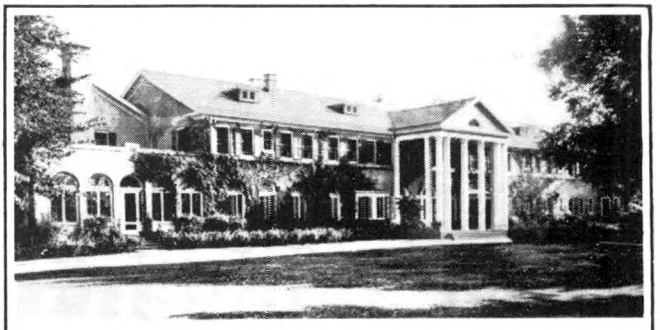
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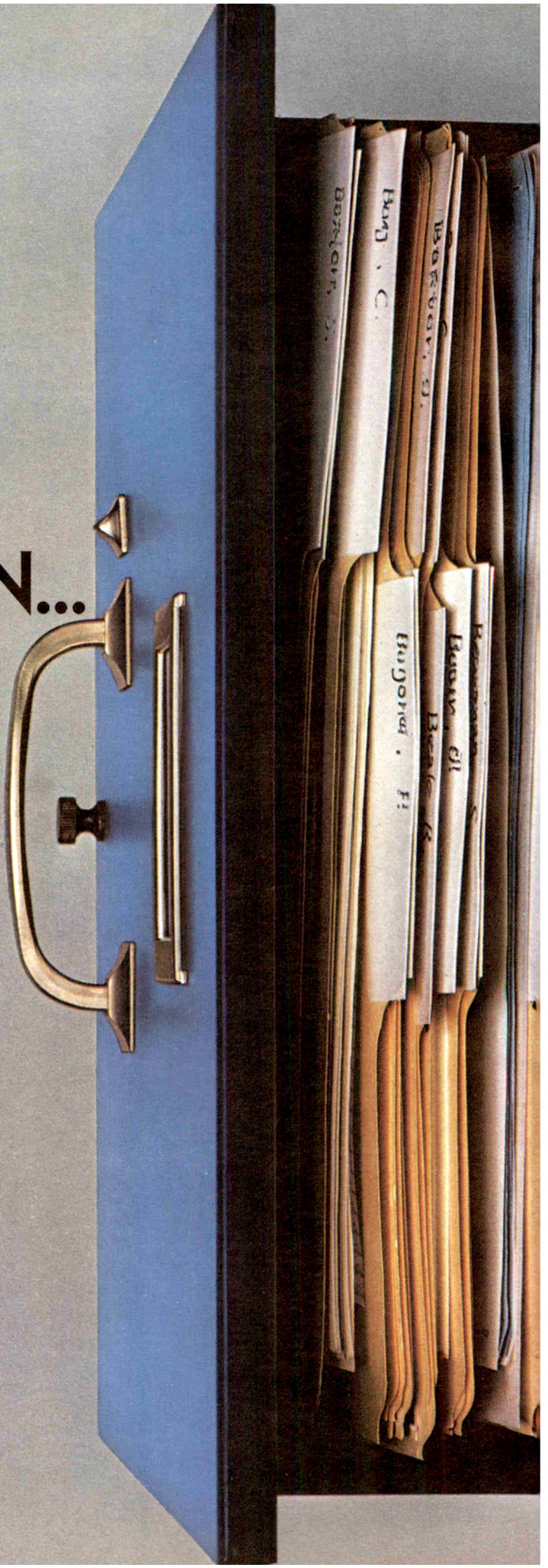
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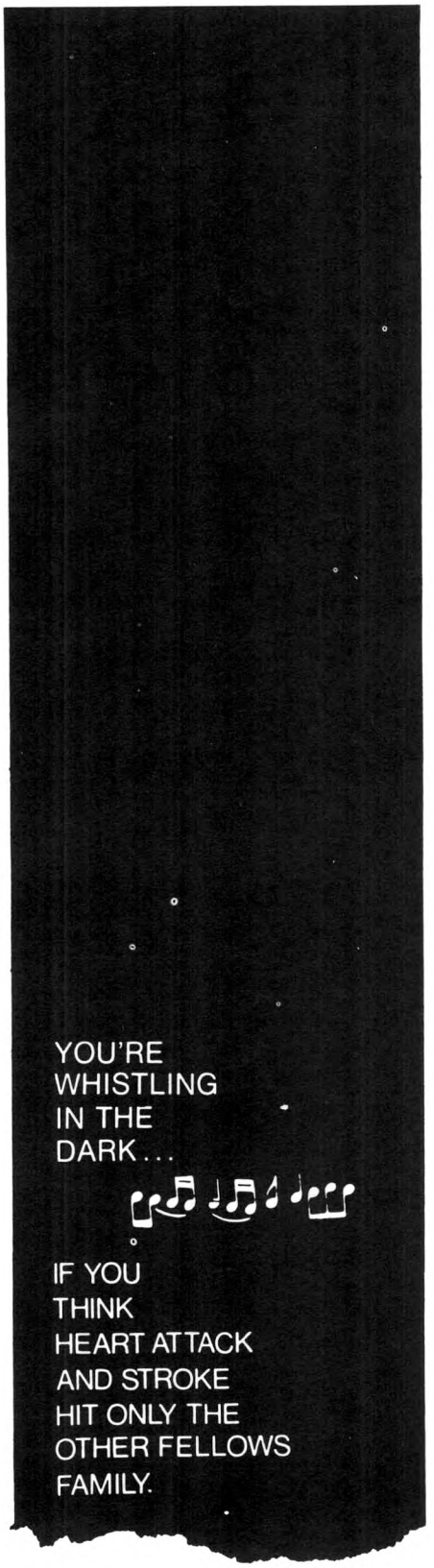
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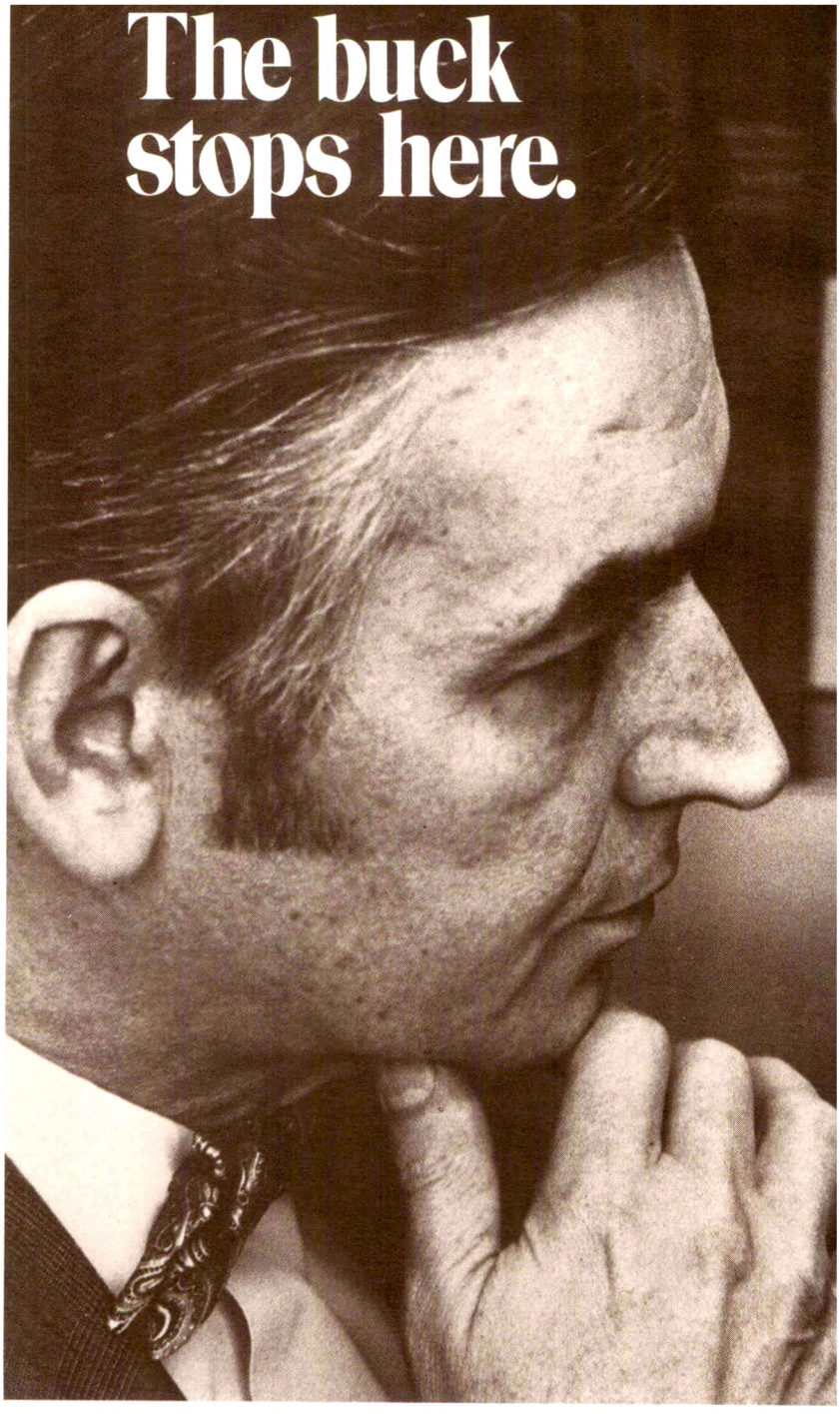
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Indication: For relief of mental depression. **Contraindications:** Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane (desipramine HCl) in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine. **Dosage:** All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink), bottles of 100 and 1000. Also, 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.



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How best to encourage a productive one-to-one relationship for treatment of this most difficult emotional problem? Establishing rapport with the depressed patient is basic to building patient confidence for productive psychotherapy. Pertofrane (desipramine HCl) can be a helpful adjunct to your therapy, particularly in the early stages, to help relieve depressive symptoms. As the depression lifts, new pathways that permit enhanced cooperation for more effective psychotherapy are opened.

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s improvement when depression
s sustained."

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1. Marshall, M.H.: Psychopharmacology of Depression: Perspectives in Research, Psychosomatics 12:49, 1971.
2. Barringer, T.J.: Clinical Trial of Desipramine in the Treatment of Depression, Am. J. Psychiatry 121:1117, 1965.

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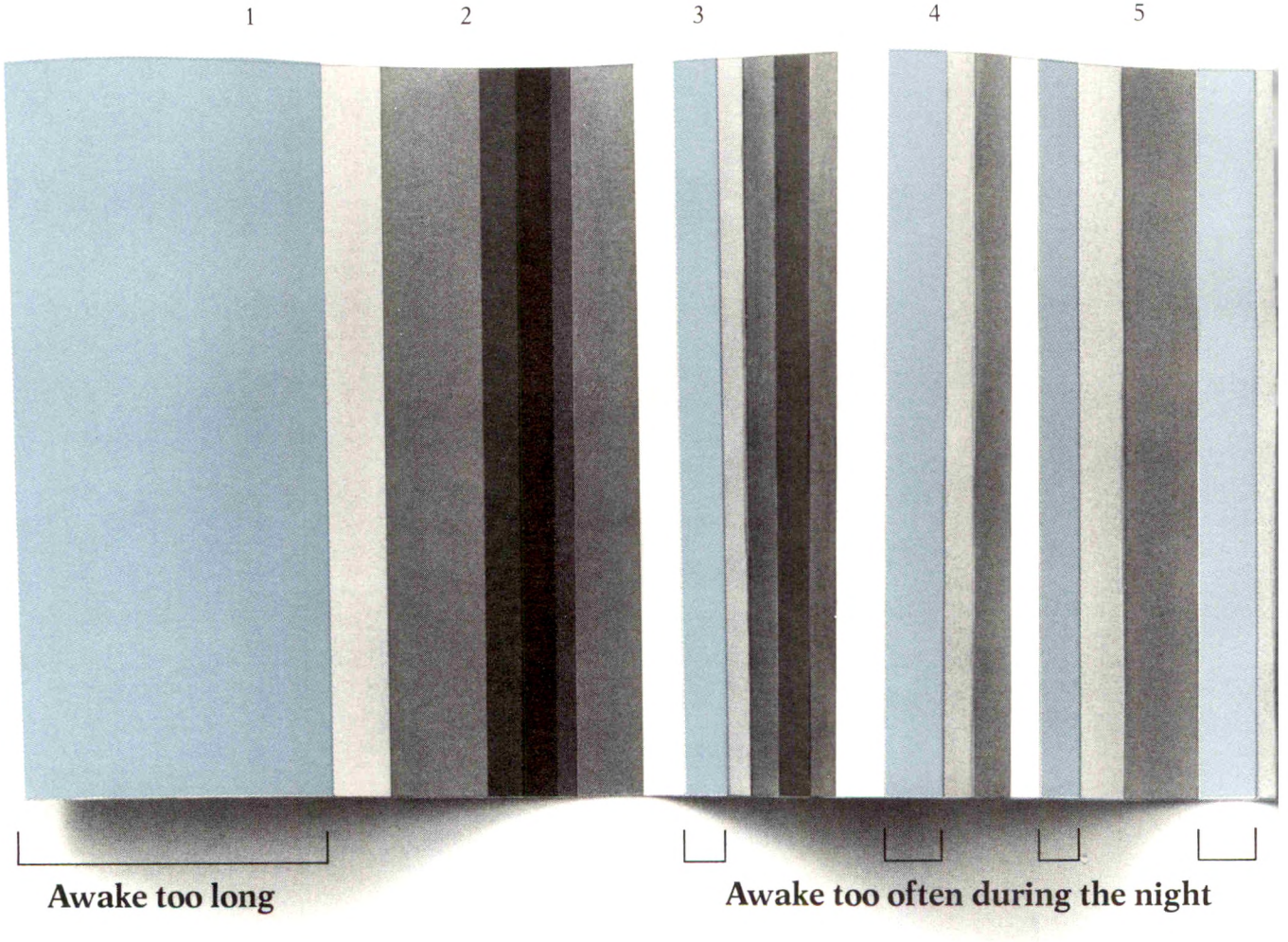
Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



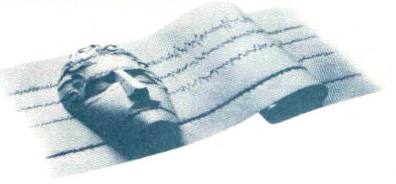
The insomnias most often occurring in young and older adults

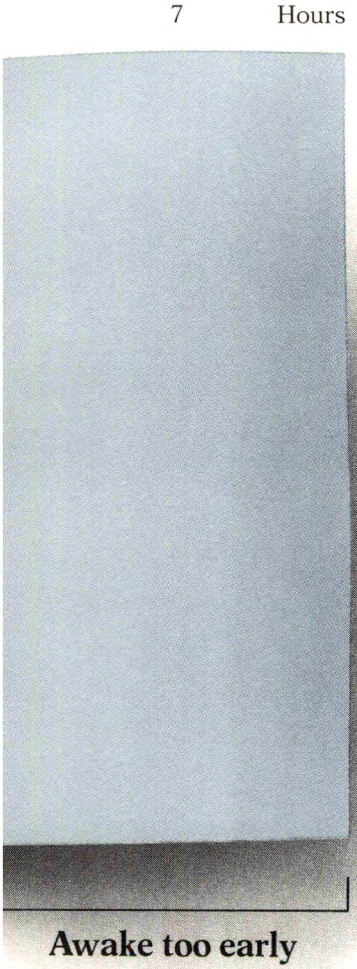
For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia





Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

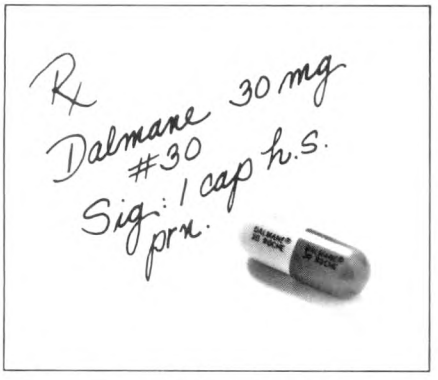
- □ induces sleep rapidly
- □ reduces nighttime awakenings
- □ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl)



- ☐ induces sleep within 17 minutes, on average
- ☐ reduces nighttime awakenings
- ☐ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

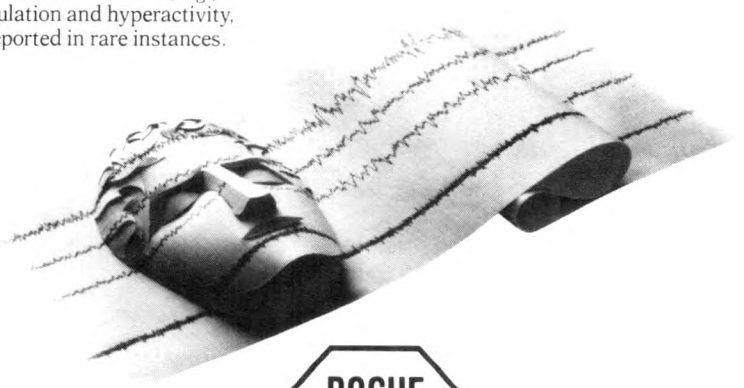
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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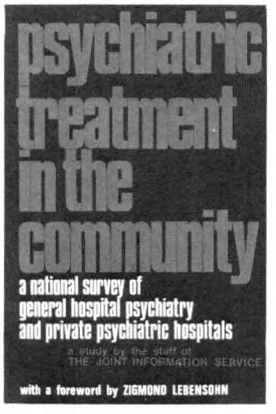
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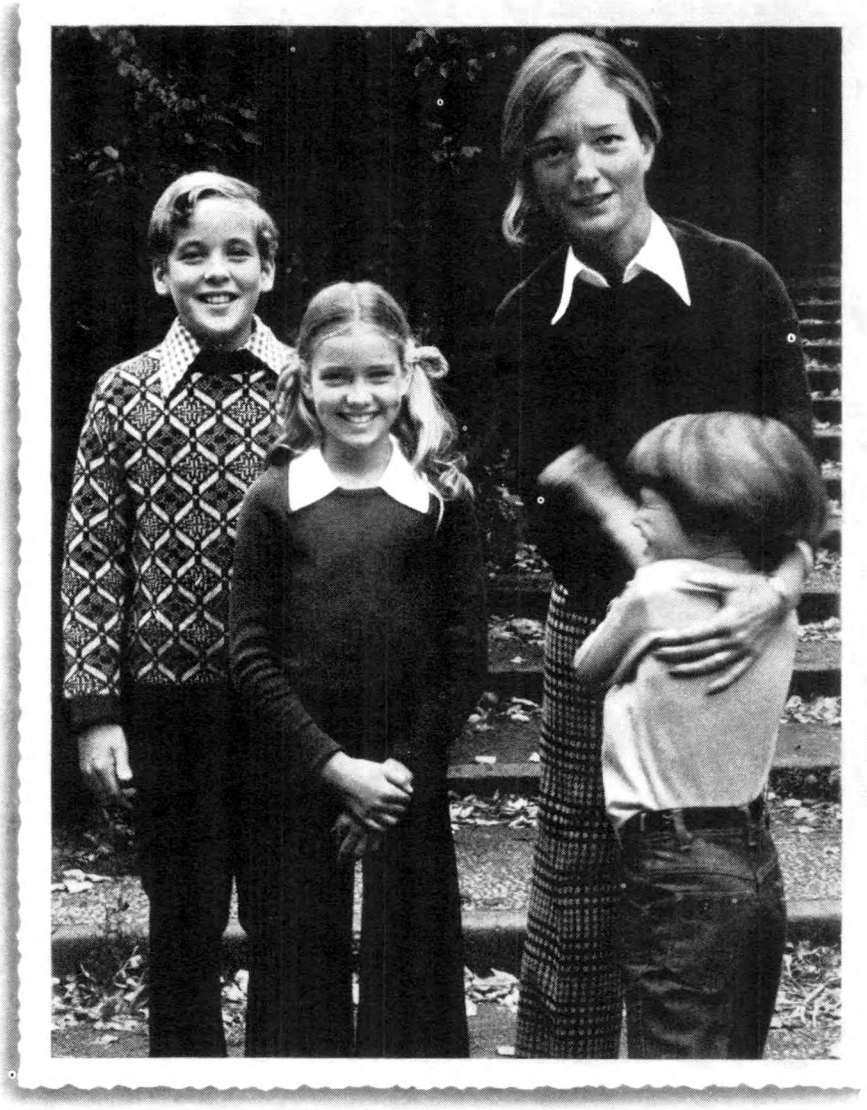
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MBD Case History #1

1971 ...a difficult child, a distraught mother Medical diagnosis: MBD



Robert Boynton,* second of five children, born October 7, 1963. Normal pregnancy and delivery.[1]

From the age of 3, Robert's mother found him "hard to handle," "wilder" than his brothers and sisters.[1]

At age 6, after an "extremely difficult" experience in kindergarten, Robert was referred to a pediatric neurologist. The examination and later psychological testing revealed a host of the neurologic "soft signs," plus an abnormal EEG.[1]

The diagnosis: average intelligence, but multiple signs of an underlying organic dysfunction.[1]

At age 7, Robert was placed in a special first-grade class called an "extended readiness program."[1]

Later that year, her child's continued problems at school and at home made Robert's mother "increasingly desperate" for help.

An MBD child on the road to maturity.

1974 ...a regular fourth-grader, accepted at home

In the opinion of the physician, methylphenidate (Ritalin) was called for to help the child over the obstacles of hyperactivity. So he initiated a trial of the drug, which was then implemented on school days only.[1]

The improvement in classroom performance and behavior was "prompt and dramatic." Robert's teacher could "scarcely believe" that he was the same child.[1]

For the past 4 years (as of April 1974), Robert has been maintained on 15 mg methylphenidate daily during school periods. During the summer he attends day camp and is not on medication. He is in a regular fourth-grade class, and behavioral problems at home have lessened. Robert's parents now find it much easier to accept their son.[1]

Note: In this presentation, clinical material has been used factually with the permission of the physician. However, identities have been concealed and names changed.



How other children with MBD can benefit from methylphenidate therapy

Of course, medication is not indicated for all MBD children; nor will all such children respond to drug therapy.

However, when pharmacotherapy is clearly indicated, the use of a widely successful drug such as Ritalin (methylphenidate) may prove to be a significant element in many complete remedial programs.

Over a decade of controlled studies has underlined the beneficial effects of Ritalin in producing improved behavior ratings,[2,3] better motor coordination,[2,4] and cognition and learning.[2,4] Indeed, it is currently the drug of choice in many MBD situations.

And side effects with Ritalin have occurred less frequently than with other stimulant drugs.[4,6,7]

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. These interruptions often reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and gradual elimination of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with medical diagnosis of MBD.



For brief prescribing information, please see following page.

Ritalin® (methylphenidate)

can help when medication is indicated

CIBA

Ritalin®
(methylphenidate)
Only when medication is indicated



Ritalin®hydrochloride Ⓒ
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children — as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.

Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.

In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

References:

1. Files of Medical Research Department, CIBA Pharmaceutical Company, Summit, New Jersey.
2. Knights RM, Hinton GG: *J Nerv Ment Dis* **148**:643-653, 1969.
3. Comly HH: *J Learning Disabil* **4**:484-490, 1971.
4. Conners CK: *J Learning Disabil* **4**:476-483, 1971.
5. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.
6. Paine RS: *Pediatr Clin North Am* **15**:779-800, 1968.
7. Conners CK: *Pediatrics* **49**:702-708, 1972.

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7 new books for psychiatrists. You probably need at least one.

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***2. HALLUCINATIONS: Behavior, Experience, and Theory**
Edited by **Ronald K. Siegel, M.D.** and **Louis J. West, M.D.**, both of the University of California, Los Angeles

Examines hallucinations as occurring on the same continuum as "real" perceptions, leading to clearer distinctions between different kinds of experience. Presents current research methodologies, as well as a unique collection of color illustrations of hallucinations which, with the volume's vivid phenomenological descriptions, enable the reader to "see" another's hallucinations. Reports of current research by the leading workers in the field help explain possible mechanisms of action. Fall 1975, approx. 528 pp. 52 illus., tent. $25.00

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***b) RESEARCH ADVANCES IN ALCOHOL AND DRUG PROBLEMS, VOL. II**
Edited by **Robert Gibbins, Yedy Israel, Harold Kalant, Robert Popham, Wolfgang Schmidt,** and **Reginald Smart,** all of the Addiction Research Foundation, Toronto, Canada. Focuses on Alcoholism. 1975, approx. 384 pp., $24.00

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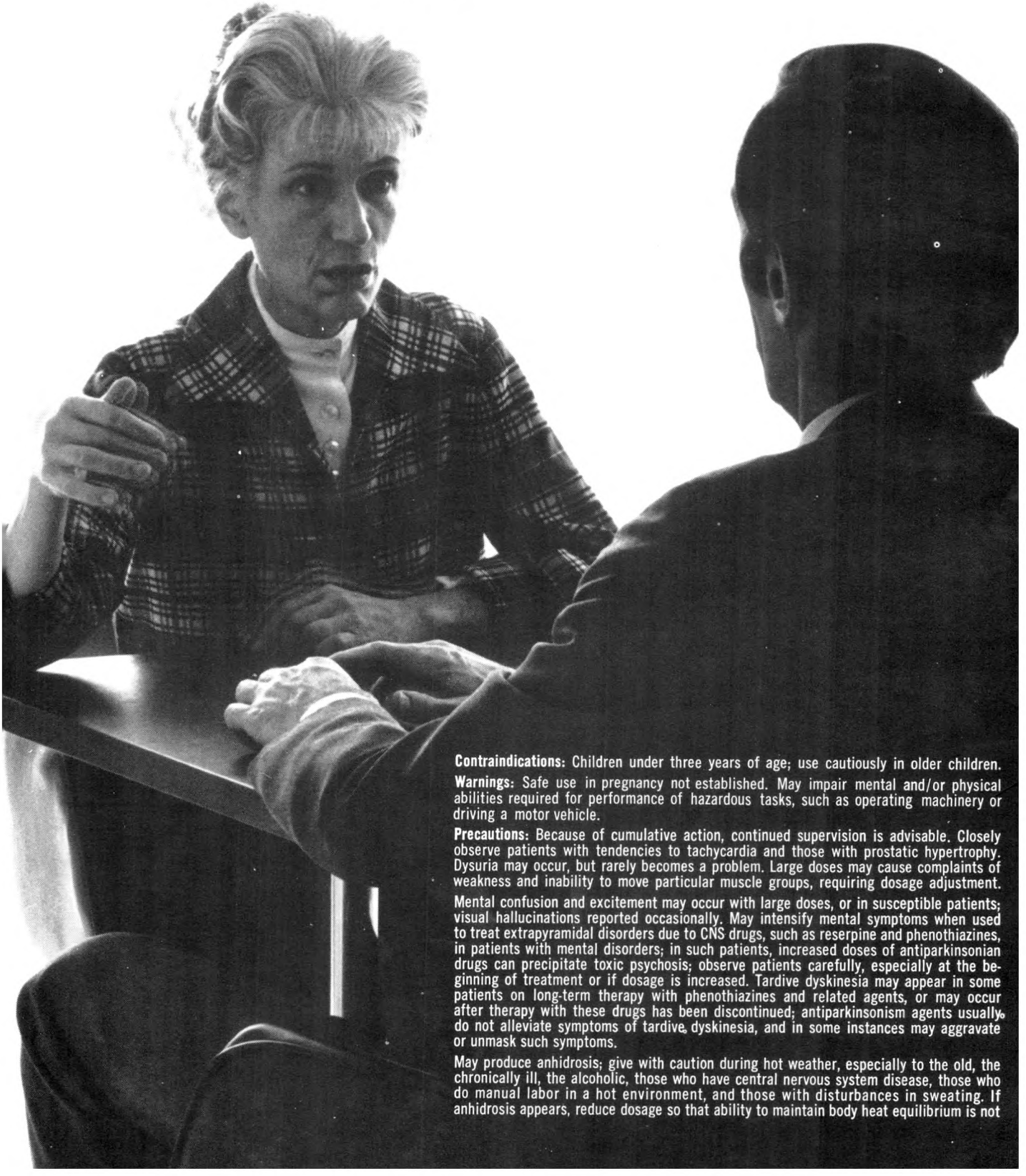
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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

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1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
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Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

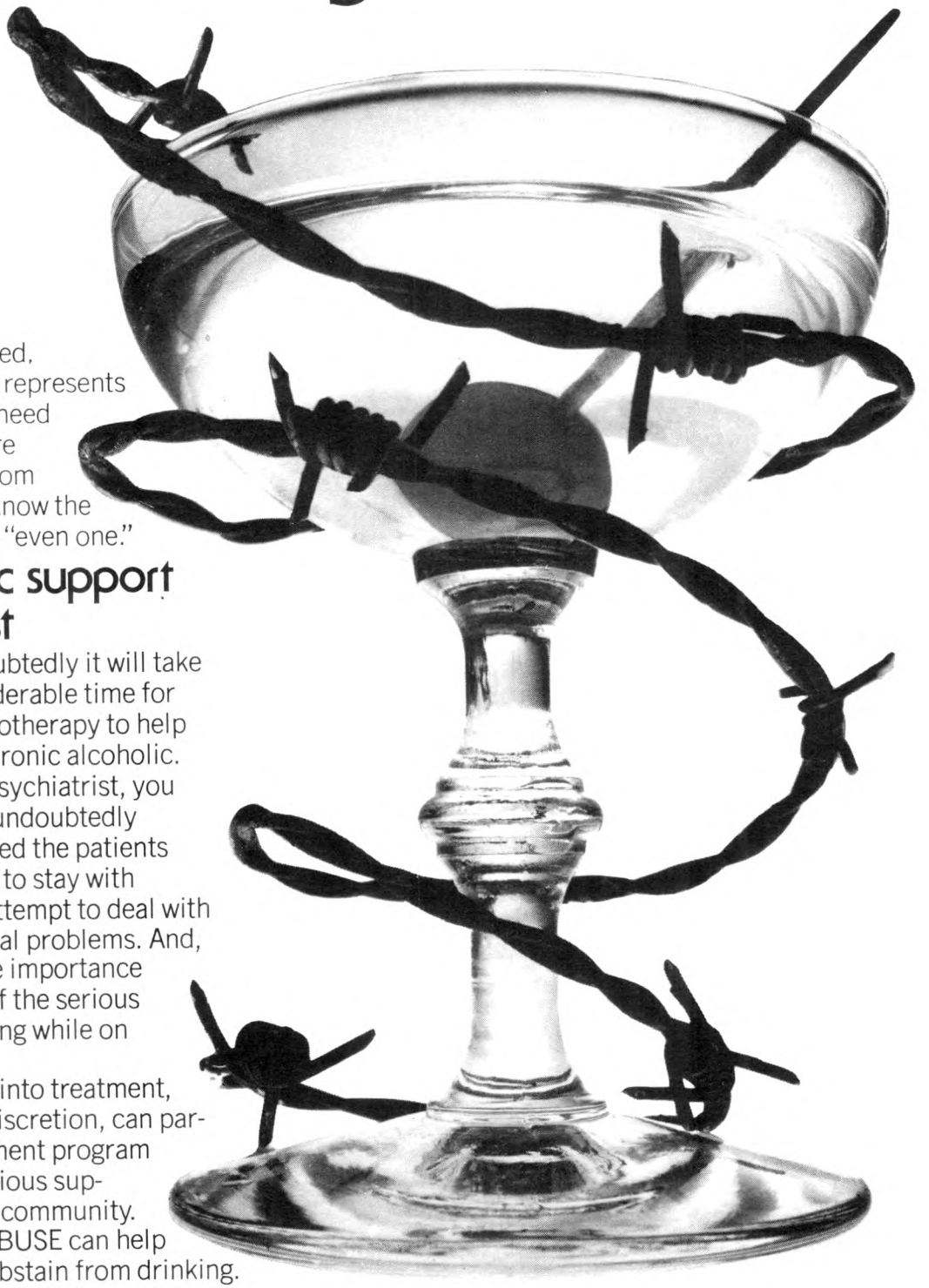
In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to COGENTIN.

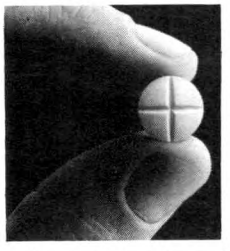
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For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) in Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, *e.g.* cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE (disulfiram) should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE (disulfiram), report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

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First day in the hospital and all efforts will be directed toward returning her to the community.

For psychotic patients with mixed anxiety-depression, Mellaril has been found useful to help patients participate more fully in the entire therapeutic program. Continued medication with Mellaril is often basic to helping patients prepare for and participate in outpatient treatment programs that bridge the gap between hospital and community.

With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

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helps in the management of psychotic patients with mixed anxiety-depression

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

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THE AMERICAN JOURNAL OF PSYCHIATRY

Some Characteristics of Psychiatric Residency Training Programs

BY LEE GUREL, PH.D.

The author summarizes responses to a major questionnaire survey of psychiatric residency training programs. In addition to providing objective data on residents, training staff, and on the training institution and its related facilities, the author presents information drawn from the narrative responses to questions on major issues facing psychiatry. These include training for dealing with critical social problems, recruitment of minority group trainees and faculty, and training in interdisciplinary collaboration and preparation for work with paraprofessionals. It is hoped that these data will facilitate answers to questions about the training psychiatrists should receive in the future by providing information about training programs in the immediate past.

THE PURPOSE of this study was to obtain quantitative descriptive data about psychiatric residency training programs. Conducted at a time when psychiatric practice and education are being subjected to criticism both from within (1, 2) and without (3, 4), the study was expected to bring to light findings that would be useful in understanding current emphases in training.

A familiar truism holds that change is one of the unchanging facts of life. This study was conducted during a period of accelerated change in the conditions influencing the delivery of psychiatric services (5). As one psychiatrist expressed it, "We live in a time when nearly every psychiatric program in the country is undergoing critical evaluation and, in some cases, major changes" (6).

This atmosphere of evaluation and change undoubtedly affected the conduct of the study. While our major purpose was to assemble heretofore unavailable "hard" data about the scope and nature of residency training, we also sought to address certain emerging and/or controversial issues; these issues will be identified and discussed.

METHOD

All active programs approved by the AMA's Residency Review Committee for training in general and/or child psychiatry (N=288) were sent questionnaires in two mailings in the spring and fall of 1972. The programs are categorized by program type, site, and sponsorship in table 1. To facilitate presentation, programs were grouped into the four categories indicated by the boxes in the table. It can be seen, for example, that one box encompasses the 28 programs offering child psychiatry training only and that another surrounds the 6+67+10+11+4=98 programs in psychiatric hospitals not operated in conjunction with a medical school. The four categories will be identified as child programs (N=28), mental hospital programs (N=98), medical school programs (N=97), and other programs (N=65)—the latter were in free-standing child/community clinics/centers or in general hospitals that were not medical school primary teaching sites.

The questionnaires requested objective information about residents, training staff, and the training institution and its affiliated facilities. In addition, training directors were asked to provide narrative responses regarding a series of issues that were of particular interest to the Na-

This paper is abstracted from the monograph *A Survey of Academic Resources in Psychiatric Residency Training*, which is available from the Publications Services Division of the American Psychiatric Association. The study was conducted under provisions of contract HSM-42-69-89 between APA and the National Institute of Mental Health; it was initiated under J.F. Whiting, Ph.D., former director of APA's Manpower Division.

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The author wishes to acknowledge the collaboration of Mary Jane Merrick, Carol Nelson, and Ina Spaner.

TABLE 1
Psychiatric Residency Training Programs by Type, Site, and Sponsorship

Site and Sponsorship	Type of Program: Child (N=28)	General (N=162)	Combined Child/General (N=98)	Total (N=288)
Psychiatric hospital, nonmedical school (N=100)				
Federal	—	6	—	6
Other public	1	67	10	78
Private	1	11	4	16
Psychiatric facility in medical school (N=99)				
In public university	1	16	38	55
In private university	1	13	27	41
Other	—	2	1	3
Psychiatric unit in nonmedical school general hospital (N=68)				
Federal	—	13	2	15
Other public	—	13	3	16
Private	7	19	11	37
Nonhospital clinic/center (N=21)				
Federal	—	—	—	—
Other public	8	1	2	11
Private	9	1	—	10

tional Institute of Mental Health (NIMH) staff involved in initiating the study. These had to do with child mental health, community psychiatry, recruitment of minority group trainees and faculty, training for increased understanding of minority cultures, training in interdisciplinary collaboration and work with paraprofessionals, training to deal with critical social problems, and training in acquiring skills in community consultation, community organization, child advocacy, program administration, and program evaluation. Narrative responses were subjected to content analyses.

Response Rate

All of the 288 programs surveyed eventually responded with data on their residents. The information requested on staffing and other program characteristics was supplied by 234 programs; 32 more reported just the staffing information. Ratings of the quality and quantity of responses from the 234 programs with complete quantitative data indicated that 148 (63 percent) could be considered good or excellent, 31 percent fair, and 6 percent poor.

The response to our request for narrative comments was considerably less satisfactory. Of the 234 programs with complete quantitative data, fewer than half (47 percent) had responses that were rated as satisfactory; more than one-third (37 percent) either did not respond or gave minimal and inadequate responses. The remaining 16 percent of the responses were considered minimal and barely adequate.

RESULTS

Table 1 shows that of the 288 programs, 28 offered training only in child psychiatry, 162 only in general psychiatry, and 98 in both general and child psychiatry. Most programs were in psychiatric hospitals that were not part of a medical school (N=100) or in psychiatric facilities that were functionally or administratively part of a medical school setting (N=99). The remainder were located in facilities associated with general hospitals that were not part of a medical school setting (N=68) or in clinics or centers not associated with a medical school or with either hospital setting (N=21).

The type of training offered was related to program sponsorship and location. At the psychiatric hospitals (almost all of which were state mental hospitals) training was typically in general psychiatry only. Programs in general psychiatry also predominated, although to a lesser degree, in general hospitals that were not part of a medical school complex. On the other hand, two-thirds of the programs in medical school settings offered both basic training in general psychiatry and advanced training in child psychiatry.

The 288 programs were located in 43 states, Puerto Rico, and the District of Columbia. It is striking that almost half of the programs (47 percent) were located in the 11 northeastern states and the District of Columbia. Also of interest is the fact that mental hospital programs were more frequently located in this northeastern area than were medical school programs, whereas the reverse was true in the rest of the country.

Residents

A total of 4,750 residents were reported in training on September 1, 1972.[1] Table 2 shows their placement by program type and by year of training. Fully 90 percent of the residents were in the first three years of training and 10 percent were in advanced training, mostly in child psychiatry. With respect to the four categories described previously, only 2.1 percent of the residents were in the 28 child programs; more than half (53 percent) were in the 97 programs in medical schools that were not exclusively child psychiatry programs.

The number of residents varied from none in 6 programs (which did not, however, consider themselves inactive or in the process of closing down) to 110 in the case of a consolidated program comprised of 3 semiautonomous programs. The median number of residents per program was 12.5.

Programs in New York State had 20.2 percent of all trainees and California had 12.5 percent. These were followed in descending order by Massachusetts, Pennsylvania, Ohio, Michigan, Illinois, Maryland, Connecticut, and Missouri. The programs in these 10 states had 3,344 residents, or 70.4 percent of the total.

[1]Follow-up a year later indicated that several of the residents had an ambiguous status and probably should not have been reported.

TABLE 2
Distribution of Residents by Year and Type of Program

Type of Program	Year of Training: First (N=1,541) N	First Percent	Second (N=1,389) N	Second Percent	Third (N=1,345) N	Third Percent	Fourth (N=348) N	Fourth Percent	Fifth (N=127) N	Fifth Percent	Total (N=4,750)
Child (N=28)	7	7.0	9	9.0	28	28.0	39	39.0	17	17.0	100
Mental hospital (N=98)	438	34.1	398	31.0	342	26.6	58	4.5	49	3.8	1,285
Medical school (N=97)	820	32.6	722	28.7	746	29.6	192	7.6	39	1.5	2,519
Other (N=65)	276	32.6	260	30.7	229	27.1	59	7.0	22	2.6	846

Staffing

Instructions for reporting teaching staff called for excluding staff who did not hold officially designated positions, who did not regularly do didactic or clinical teaching of psychiatric residents, and who possibly interacted only casually with residents. Consultants and lecturers were not to be reported unless they were both regularly scheduled and averaged at least one hour a week with residents. Data-handling procedures were designed to provide an unduplicated count of staff within the unit of a program and its associated facilities. However, a particular individual could have been reported by more than one program (e.g., a faculty member who worked part-time in more than one program).

More than 8,000 psychiatrists were reported to be teaching in residency programs. Even though this figure does not necessarily reflect 8,000 separate individuals, particularly among the more than 5,000 part-time people, there can be little doubt that a considerable proportion of the nation's psychiatric manpower is involved in the training of future psychiatrists.

Table 3 presents a breakdown of psychiatrists in terms of board certification and full-time versus part-time involvement for the 266 programs that responded fully to the set of staffing items. Part-time appointments were relatively more frequent in child psychiatry training programs and least frequent, relatively speaking, in the case of mental-hospital-based programs. For the three program types other than those based in mental hospitals, both part-time and full-time faculty were more often board certified than not. In the mental-hospital-based programs, however, less than one-third of the full-time psychiatric teaching staff were certified.

Only 302 full-time and 424 part-time neurologists were reported to be involved in psychiatric residency training. The neurologists were more likely than the psychiatrists to be board certified (76 percent versus 56 percent), and they were somewhat more often full-time (42 percent versus 37 percent).

Data about other teaching staff are reported in table 4. The category of social scientist included social workers, sociologists, anthropologists, etc.; physical scientist included biologists, chemists, etc.; and other physicians included all M.D.s and D.O.s who were not psychiatrists or neurologists. Perhaps the most noteworthy finding re-

TABLE 3
Number of Psychiatrists Teaching in Residency Programs

Psychiatrists on Faculty	Type of Program: Child (N=17)	Mental Hospital (N=94)	Medical School (N=95)	Other (N=60)	Total (N=266)
Board certified					
Full-time	24	332	997	272	1,625
Part-time	74	618	1,758	656	3,106
Total	98	950	2,755	928	4,731
Noncertified					
Full-time	8	718	538	241	1,505
Part-time	44	461	1,113	590	2,208
Total	52	1,179	1,651	831	3,713
Both certified and noncertified					
Full-time	32	1,050	1,535	513	3,130
Part-time	118	1,079	2,871	1,246	5,314
Total	150	2,129	4,406	1,759	8,444

TABLE 4
Number of Other Physicians, Psychologists, Social Scientists, and Physical Scientists Teaching in Residency Programs

Classification	Type of Program: Child (N=17)	Mental Hospital (N=94)	Medical School (N=95)	Other (N=60)	Total (N=266)
Other physicians					
Full-time	0	233	242	26	501
Part-time	4	144	147	39	334
Total	4	377	389	65	835
Psychologists					
Full-time	42	359	684	275	1,360
Part-time	57	193	366	138	754
Total	99	552	1,050	413	2,114
Social scientists					
Full-time	74	908	927	440	2,349
Part-time	54	225	306	124	709
Total	128	1,133	1,233	564	3,058
Physical scientists					
Full-time	1	71	168	46	286
Part-time	0	25	53	6	84
Total	1	96	221	52	370

TABLE 5
Number of Programs Offering Experience with Selected Patient Types/Conditions

Patient Type/Condition	Type of Program: Child (N=9) N	Child (N=9) Percent	Mental Hospital (N=89) N	Mental Hospital (N=89) Percent	Medical School (N=86) N	Medical School (N=86) Percent	Other (N=50) N	Other (N=50) Percent	Total (N=234) N	Total (N=234) Percent
Neurosis/behavior disorder, child/adolescent	9	100	77	87	79	92	42	84	207	88
Psychosis/autism, child/adolescent	9	100	69	78	74	86	36	72	188	80
Juvenile delinquency	5	56	26	29	35	41	18	36	84	36
Drug abuse, child/adolescent	5	56	16	18	30	35	11	22	62	26
Psychophysiologic disorder, child/adolescent	7	78	75	84	76	88	47	94	205	88
Mental retardation	8	89	53	60	41	48	19	38	121	52
Neurosis, adult	2	22	88	99	86	100	50	100	226	97
Acute psychosis, adult	2	22	88	99	86	100	50	100	226	97
Chronic psychosis, adult	—	—	85	96	62	72	31	62	178	76
Organic brain syndrome	4	44	68	76	40	47	30	60	142	61
Alcoholism	2	22	84	94	80	93	49	98	215	92
Drug dependency, adult	2	22	73	82	76	88	49	98	200	85
Personality disorders	7	78	70	79	68	79	45	90	190	81
Disorders of the aged	—	—	59	66	38	44	29	58	126	54
Medical/surgical patients	5	56	42	47	73	85	47	94	167	71
Other*	3	33	16	18	12	14	12	24	43	18

*Almost exclusively acute situational or transient disorders.

flected in table 4 is the relatively large number of psychologists and social scientists reported to be involved in teaching residents. Especially remarkable is the relatively higher proportion of full-time appointments for these groups compared with psychiatrists and neurologists.

Patient Contact

The availability to residents of experience with selected patient types and conditions was tabulated for the 234 programs that returned complete responses regarding this issue and the issues dealt with in the two following paragraphs. These data are presented in table 5, which indicates results generally in line with expectations for the particular program types. For example, with the exception of most of the child programs and 1 mental hospital program, all programs saw neurotic and acutely psychotic adults; all child programs saw neurotic and psychotic/autistic children.

Alcoholic and drug-dependent adult patients were seen in a surprisingly high proportion of the non-child programs (92 percent and 85 percent, respectively). On the other hand, juvenile delinquents, young drug abusers, and patients with organic brain syndromes were seen in fewer programs than many authorities would probably have anticipated.

It was found that an average of 11 of the 16 listed conditions were seen in the 3 non-child program categories, with a range from 16 down to only 3 in the case of 1 mental hospital program. Thus it appears that some training programs are based in rather specialized settings and that arrangements for experiences in other settings are limited. However, it should be noted that these data reflect the *availability* of certain kinds of patients; whether residents actually saw patients of the particular types was not determined.

Treatment Modalities

A related issue involves the extent to which specified treatment methods were in use at the program and its associated facilities. It is evident from the data in table 6 that certain methods were practically universal—individual psychotherapy, group psychotherapy, psychotropic drugs, crisis intervention, and, to a slightly lesser extent, electroconvulsive therapy. On the other hand, insulin coma/subcoma therapy, carbon dioxide therapy, psychoanalysis (excluding psychoanalytically oriented psychotherapy), sensitivity training/training laboratories, and psychodrama were used very infrequently. The "other" category produced many responses, 90 percent of which reported either hypnosis or other somatic treatment. Affirmative responses ranged from 2 medical school programs reporting the use of 13 modalities to 2 child programs reporting 1 and 2 methods, respectively. The median number of modalities per program was approximately 8. Again, the reader is cautioned that the data reflect treatment methods in use at the program training site; the breadth or depth of experience of individual trainees is not known.[2]

[2]A reviewer of this manuscript suggested that these data confirmed his/her impression that programs overemphasize depth of experience in a few modalities at the expense of breadth of experience. He/she offered as an example of this the extreme difficulty of finding an otherwise well-trained psychiatrist who is competent and available to administer electroconvulsive therapy—especially on the east coast.

TABLE 6
Number of Programs Offering Experience with Selected Treatment Modalities

Modality	Type of Program: Child (N=9) N	Child (N=9) Percent	Mental Hospital (N=89) N	Mental Hospital (N=89) Percent	Medical School (N=86) N	Medical School (N=86) Percent	Other (N=50) N	Other (N=50) Percent	Total (N=234) N	Total (N=234) Percent
Psychotropic drugs	7	78	89	100	86	100	50	100	232	99
Electroconvulsive therapy	1	11	83	93	82	95	46	92	212	91
Insulin coma/subcoma therapy	—	—	2	2	4	5	2	4	8	3
Carbon dioxide therapy	—	—	3	3	1	1	1	2	5	2
Individual psychotherapy	9	100	89	100	86	100	50	100	234	100
Psychoanalysis, classical and variants	—	—	3	3	9	10	2	4	14	6
Behavior modification, token economy	3	33	31	35	38	44	13	26	85	36
Group psychotherapy	8	89	89	100	86	100	50	100	233	99
Sensitivity training/training laboratory	—	—	6	7	4	5	2	4	12	5
Psychodrama	—	—	6	7	11	13	6	12	23	10
Sociomilieu: self-government, attitude, etc.	1	11	37	42	39	45	24	48	101	43
Conjoint/family	7	78	49	55	67	78	34	68	157	67
Crisis intervention, walk-ins, etc.	7	78	89	100	85	99	50	100	231	99
Alcoholism clinic/program	1	11	36	40	35	41	25	50	97	41
Drug clinic/program	2	22	33	37	41	48	27	54	103	44
Other	3	33	57	64	61	71	39	78	160	68

TABLE 7
Number of Programs Offering Training in Related Fields

Field	Type of Program: Child (N=9) N	Child (N=9) Percent	Mental Hospital (N=89) N	Mental Hospital (N=89) Percent	Medical School (N=86) N	Medical School (N=86) Percent	Other (N=50) N	Other (N=50) Percent	Total (N=234) N	Total (N=234) Percent
Nursing affiliate	2	22	61	69	57	66	31	62	151	65
Nursing clinical specialist	1	11	13	15	10	12	3	6	27	12
Social work master's/placement	5	56	48	54	59	69	37	74	149	64
Psychology (doctoral)	4	44	50	56	63	73	31	62	148	63
Mental health associate (A.A. degree)	—	—	6	7	2	2	1	2	9	4
Medical internship	6	67	53	60	83	97	44	88	186	79
Rehabilitation specialist	2	22	27	30	27	31	15	30	71	30
Speech and hearing (M.A., Ph.D.)	—	—	1	1	—	—	1	2	2	1
Dietetics	1	11	2	2	1	1	3	6	7	3
Other	3	33	29	33	37	43	10	20	79	34

Related Training Programs

One of the objectives of a residency is to train the future psychiatrist to work in the collaborative multidisciplinary arrangements that are increasingly common in mental health service delivery systems. Since shared training experiences are generally thought to foster the development of the skills and attitudes involved in effective multidisciplinary effort, we collected data on the extent to which training related to academic or professional requirements other than for medical specialists was offered at the program site and/or its associated facilities. The availability of 8 such training programs and the medical internship is shown in table 7.

The medical internship was the most frequently reported related training experience: it was offered at 79 percent of the programs and was almost universally available in medical school programs. A cluster of nursing, social work, and psychology programs was next in frequency. Dietetic, speech and hearing, and mental health associate programs were rare, and there were fewer rehabilitation-type programs than might have been expected.

In retrospect, the item on related training should have specifically mentioned 2 or 3 additional groups. Included within the "other" category are 42 programs in pastoral counseling and similar ministerial training; 15 programs in vocational counseling, counseling and guidance, and/or subdoctoral psychology; and 7 programs in special education. A long list of other fields was com-

piled, but there were only 1 or 2 reports of each of these programs (law, pharmacy, hospital administration, etc.).

In two-thirds of the programs, four or fewer kinds of related training programs were being conducted. As almost 20 percent of the residency programs had *no* related training (or none other than medical internship), such common-site training must be considered surprisingly infrequent, particularly in areas outside the traditional mental health professions.

SOME SPECIAL ISSUES

The status of certain aspects of residency training content can be adequately inferred from the quantitative data presented in the preceding section. Our results suggested that 1) opportunities for experience with certain patient conditions vary, 2) some content is essentially universal, 3) some content has been largely phased out (e.g., insulin coma and carbon dioxide therapies), and 4) still other content (e.g., behavior modification and sociomilieu methods) is available in only a small number of the programs. To complement those data, narrative responses were elicited about what we perceived to be emerging emphases, points of controversy, or areas of suspected deficiency in psychiatric residency training.

The reader is cautioned that the findings in the following paragraphs are subject to limitations of response bias. The kind of extended speculation that was included in the parent monograph on the possible reasons for (and the impact of) the lowered rate of response to this part of the survey cannot alter this central fact. There is simply no way of knowing how respondent and nonrespondent programs differ and what influences operated to produce the selective response. What follows is based on the 162 programs (56 percent) that returned usable responses on the seven issues. These responses varied from the single word "none" to 44 pages on one issue.

Child Mental Health

We initially assumed that because all of the programs surveyed were accredited, their didactic and clinical content would meet the accreditation requirements of

> sufficient experience in child psychiatry . . . for the resident in general psychiatry to acquire an understanding of the biology of human growth and development and of the maturational process in infancy and childhood as influenced by the family and by the sociocultural milieu of which the family is a part. This knowledge should be imparted through formal didactic instruction and through supervised clinical experience with children. (7, p. 373)

Our tabulations support the conclusion that the programs varied widely in interpretation of the "sufficient experience" requirement. The responses ranged from that of 1 program which explicitly reported no child mental health content and no provision for placement at child facilities, through 2 programs in which such instruction was elective, to 40 programs with teaching and experience throughout all three years. Although didactic instruction in normal development was frequently reported, only 8 programs reported provision for actual experiences with normal children; e.g., experience in well-baby clinics and observation of and/or participation in nursery school programs. One program reported experience with normal children throughout all three years of the basic residency, and 5 programs indicated opportunities for research in child psychiatry.

There was little indication of experimentation with the child mental health curriculum; the few reported instances could not be considered major departures from the conventional. We do not know to what extent the programs simply did not report innovative curriculum developments because they were not directly requested to do so, but this could hardly explain the almost total absence of references to innovative approaches.

The fact that child mental health content headed the list of issues of special concern in the survey suggests that the APA and NIMH personnel who planned the study may have questioned how well this content was being covered in basic psychiatry training programs. The data suggest that such doubts may be well founded. It appears that there is reason to doubt not only the adequacy of coverage of child mental health but even whether some programs continue to meet the minimum standards for approval.

Interdisciplinary Collaboration

Responses concerning the issue of interdisciplinary collaboration in psychiatric training were placed in five categories, as follows: 1) collaboration with other medical specialties, e.g., "resident may be asked to consult to other parts of the hospital" (N=7); 2) joint seminars and/or conferences, i.e., participation in common didactic activities (N=15); 3) common assignment with other disciplines to patient caré situations, e.g., admission, patient planning, case review, or discharges (N=44); 4) an explicitly designed team approach to patient care involving joint decision making and shared responsibility (N=59); and 5) a strongly emphasized commitment to an explicitly designed team approach, with reciprocal training and supervision (N=33). There were 3 instances of no response and 1 negative response.

We found that 43 percent of the programs reported only a very rudimentary level of interdisciplinary collaboration, whether with medical colleagues or members of allied nonmedical professions. In spite of the fairly large numbers of nonmedical personnel and of nonpsychiatrist physicians involved in psychiatric education, it appears that systematic preparation for, exposure to, and involvement in interdisciplinary collaboration is quite minimal for many psychiatric residents. This finding is consistent with our previously noted findings on the relative infrequency of common-site training.

Working with Paraprofessionals

Having noted the limited preparation of residents for interdisciplinary collaboration, we do not find it surprising that preparation for work with paraprofessionals was reported to be even more limited. In fact, it was often un-

clear whether the respondents distinguished the unique connotation of the term "paraprofessional"—some obviously equated "paraprofessional" with "multidisciplinary" and reported material on social workers, psychologists, and other physicians.[3] Despite these misunderstandings, program responses clearly indicated little if any systematic preparation of residents for work with paraprofessionals. In fact, not one response could be interpreted as describing such preparation.

Many respondents did report the availability of opportunities for working with paraprofessionals by virtue of on-the-job contact and daily interaction. Several respondents turned the issue around and described situations in which residents were teaching paraprofessionals rather than being taught to work with the paraprofessional.

Clearly, training programs provide little systematic preparation for residents to work collaboratively with either the more traditional multidisciplinary mental health team or the newer paraprofessional. This is not to say that the contributions of nonpsychiatrist groups were unrecognized or denigrated—in fact, a number of respondents offered testimonials to their importance. Rather, it appears that there is a widespread albeit implicit assumption that simple exposure to other mental health workers is all that is necessary to enable the resident to work effectively with them. Alternatively, it is possible that the importance of explicit training for work with other professionals and paraprofessionals is recognized but is not considered sufficiently important to warrant inclusion in an already heavy training regimen. Whatever the explanation, it is clear that preparation of residents to work with other personnel is at best informal and more often than not nonexistent.

Recruitment of Minorities and Understanding Other Cultures

Content analyses in this area were organized within three general categories of response: mechanisms for recruitment, numbers of minority residents and faculty, and efforts to promote understanding of minority subcultures.

Recruitment. Five types of responses regarding recruitment efforts could be distinguished: 1) statements that no special effort was being made but that discrimination was not practiced (N=42); 2) generalized, unspecific statements that efforts to recruit minorities had been made (N=56); 3) statements that a minimal level of affirmative action was being implemented, e.g., advertising in professional and/or minority publications or letters to medical schools and to graduating medical students (N=16); 4) statements indicating a strong affirmative action program, evidenced by recruitment efforts directed specifically toward medical schools with large minority populations by letters to deans, visits to the schools, and discussions with their students, and by personal contact with other minority psychiatrists (N=12); and 5) no response (N=36).

Numbers of minority residents and faculty. Although they were not specifically asked to do so, 27 programs volunteered specific numbers of minority trainees and faculty. These data are at best suggestive—we do not know, for example, whether other programs could have responded with numbers or whether foreign medical graduates were reported as blacks, Spanish-speaking, etc. The desirability of more systematic data in this area is obvious.

Understanding of minority subcultures. There were 52 programs that did not address this issue and 5 that simply indicated no efforts in the direction of furthering residents' understanding of minority groups or foreign cultures. Among the remaining 105 respondents, 46 indicated that residents were exposed to experiences with minority group members in the course of everyday contact with patients and other staff and/or as a result of placements in community settings. Fifty-nine programs indicated an explicit effort in this area either through didactic instruction alone (N=29) or instruction plus the kinds of exposure just described (N=30). Instructional mechanisms included informal discussions, lectures, seminars, and workshops.

A recurring theme among the respondents was that in spite of their efforts and good intentions they had not been able to recruit women and minority group members simply because they were not available. A common observation concerned the necessity for increasing the number of minority group applicants to medical schools before there could be an increase in minority persons in the basic psychiatry residency program. Other comments suggested that although the area of minority group recruitment is being addressed with less than universal and vigorous attention, there is a growing awareness of the issues, and a few attempts have been made to resolve them. For example, several programs indicated that they provided or were planning to provide opportunities for residents to learn Spanish. Six programs noted special scheduling provisions for women residents.

Training To Deal with Social Problems

Responses to this item separated the issue of social problems into three components: 1) alcoholism and drug dependency as medical problems; 2) alcoholism and drug dependency as social problems; and 3) racism, poverty, etc., as related but separable problems.

Alcohol and drug abuse. Training programs accepted responsibility for preparing residents to deal with alcohol and drug abuse—in sharp contrast to other issues dealt with in this section. Excluding several ambiguous responses and nonresponses, there was clear indication that instruction in the medical management of alcoholism and drug dependency was offered. The content of such instruction consisted for the most part of emergency man-

[3]This paper follows the convention of defining the paraprofessional role as working directly with clients, under general (as opposed to close, continuing) professional supervision, and for which brief, intensive, specialized training is usually required, typically at the sub-baccalaureate level, as opposed to a role requiring possession of (or working toward) a terminal degree defining a journeyman level for a given field. Typically regarded as paraprofessionals are physician assistants, indigenous mental health workers, new careerists (usually with the A.A. degree), drug counselors, etc.

agement of toxic conditions, pharmacological methods to treat alcoholism and drug abuse, and psychotherapeutic emphases in longer-term management. The programs indicated (specifically, in some cases) that alcoholism and drug abuse had long been recognized as among the problems psychiatrists deal with and need to be trained for.

Surprisingly, most of the training and experience in these areas occurred either in the classroom or in a hospital-based setting; for every instance of teaching/experience in a nonhospital community setting there were three instances in the classroom and/or hospital.

In contrast to training in medical management, little mention was made of training to deal with drug and alcohol abuse as social problems—granting, of course, that the distinction between medical and social problems is necessarily arbitrary. Attention to alcoholism and drug abuse as social problems could be discerned only in reports of the involvement of residents in walk-in crisis clinics, "hot line" services, halfway houses, etc.

Racism, poverty, etc. Responses regarding racism and poverty generally fell into two categories, one that questioned whether these were legitimate concerns of psychiatric training, and another that took the position that these problems were simply too broad and too pervasive to be addressed by psychiatry. The only affirmative responses reflected programs that conveyed information to residents about the availability of welfare resources, both social and financial, and the complexities of welfare systems.

Other problems. Eleven programs extended their narrative descriptions of training in critical social problems beyond the issues suggested in the question. Six of these reported didactic content in the areas of suicide, aging, unemployment, unwed mothers and unwanted pregnancy, therapeutic abortion, women's liberation, criminal or antisocial and aggressive behavior, and the psychiatric role in draft deferment. Three of the 11 programs reported the availability of clinical experience in geriatric settings.

Community Psychiatry

Responses to this item were classified within a series of categories of increasing involvement:

1. No content in community psychiatry (N=2).
2. General, unspecified statements of content (N=5).
3. Didactic training only (N=10).
4. Didactic training plus clinical experience in hospital service areas (N=13). Community involvement in this category was so classified largely as a result of dealing with families of patients and with community agencies referring patients.
5. Didactic training and hospital-based experience, plus service and/or consultation with agencies such as schools, jails, prisons, other general hospitals, visiting nurses, courts, children's centers, etc. (N=58). These served a specific community program rather than a broader geographic area.
6. Didactic training, in-hospital service, contact with community agents, and experience at comprehensive mental health centers serving entire catchment areas (N=43). Opportunities for training at this level included not only center services but also the outreach programs they conducted.
7. All of the training options in the previous category plus additional elective experience in community psychiatry in extensive and/or innovative areas (N=31). This category included opportunities in evaluation and development of mental health delivery systems, in health maintenance organizations, industrial consultation, multiple outreach or satellite clinics, research and evaluation, training programs for paraprofessionals, innovative treatment approaches, and programs unique by virtue of size, geography, and/or multiplicity of services.

About half of the respondents (46 percent) reported a level of training in community psychiatry beyond what could be considered the traditional pattern of didactic instruction, hospital-associated experience, and consultation with community agencies. Other evidence lends support to the impression that the movement into the community is increasing. One respondent stated, "The concepts of community psychiatry have not been central in the development of our training program to date. The pressures of the current events are moving us in that direction now." It is probable that the 46 percent of the programs reporting extensive community involvement represent the cutting edge of a trend. Seven programs reported that their residents received part of their training at 1 of 3 training programs in community psychiatry—the Center for Training in Community Psychiatry and Mental Health Administration at the University of California, Berkeley, the Laboratory for Community Psychiatry at Harvard, and the Community Psychiatry Training Program at Yale.

Teaching of New Skills

Under the heading of "new skills," the program directors were asked to describe training content in five areas: community consultation, community organization, child advocacy, administration, and program evaluation. With the partial exception of community consultation, there were far fewer affirmative responses on these items than on the preceding issues. The low level of the responses could have resulted from the fact that these issues were addressed at the end of a time-consuming task to which many respondents had obviously devoted considerable thought. In addition, a number of respondents explicitly questioned whether two of the areas in this section, community organization and child advocacy, had a legitimate place in the basic residency program.

Community consultation. Responses to the issue of community consultation were generally in line with our earlier finding that fewer than half of the programs had moved beyond a fairly traditional pattern of involvement with community-based agents and agencies.

Of the 162 programs (one of which did not respond) 82 indicated little or no training content or experience in community consultation. The largest single type of involvement was rotation in community-based clinics and community mental health centers (N=61). Twenty-four programs reported consultation or other participation by

their residents in the schools, and 20 reported involvement of residents in some facet of the legal-judicial-prison system. In all, 46 programs (28 percent) were rated as reporting substantial involvement and/or explicit didactic content in community consultation.

Community organization. This area was rarely reported as being covered in training program curriculums. As already noted, several respondents volunteered the opinion that community organization was not an area of psychiatric expertise and/or concern. The 14 affirmative responses indicated that coverage was achieved largely through practicum assignments rather than didactic instruction. Placement sites included satellite and outreach activities of a teaching hospital, advisory councils of community mental health centers, a health maintenance organization, a metropolitan health planning agency, and a military community.

Child advocacy. Only six programs cited specific instances of residents' participation in child advocacy efforts; interestingly, only 1 instance was within a school system. Other activities included consultation to legislators and lobbying for legislation, consultation with legal personnel about the civil rights of children, and involvement in a child advocacy program funded by an Office of Economic Opportunity grant.

It is difficult to know how much of the involvement in child advocacy represented an emphasis on the part of the training program and how much reflected an individual's pursuit of his/her personal interests. Because the distinction was not always clear, essentially personal activities that reflected the resident's role as a citizen rather than as a psychiatrist in training (e.g., letter writing, speaking to activist groups, etc.) were not tabulated as affirmative responses.

Administration. The inclusion of administration in this section reflects the fact that there has to date been little formal preparation of psychiatrists to assume administrative responsibilities. Data abstracted from program responses—over one-fourth simply ignored the issue—indicate that only 8 programs offered didactic material oriented toward developing administrative skills. An additional 28 programs reported that experience requirements were structured to increase the resident's administrative know-how above what would normally be learned by assignment as a ward administrator or as chief resident. That formal training in administration was not commonly seen as a component of the residency program could also be inferred from respondents' references to the availability of such training at the Harvard and Berkeley facilities.

Program evaluation. Response to this question was similar to the responses for training in community organization, child advocacy, and administration. Only 13 of the 27 programs responding affirmatively addressed program evaluation in any direct sense; the others responded in terms of teacher evaluation and self-assessment. Participation in activities that might reasonably be considered evaluation took place primarily within the teaching hospital setting. Activities consisted of participation in programs of consumer evaluation and of apprenticeship-type assignments in efforts to evaluate service agencies under a grant or contract.

COMMENT

It has been said that the transition from the 1960s to the 1970s was marked by a general disillusionment with science and technology as a basis for improving the human condition. The parallel growth of humanistic philosophies brought an increased concern with the quality of human life and a view of health as one of the basic rights of people. These emphases, among others, have resulted in an increased demand for mental health services in general and for psychiatric services in particular.

However, social change has done more than merely expand the public's demand for an increased quantity of psychiatric services. Attempts to make these services more available and accessible have emerged from the crucible of governmental-professional interaction. They have been expressed in the form of differential government support for certain kinds of programs and mental health delivery systems. The results of these efforts, to mention only a few examples, are evident in the expansion of the community mental health center program, the development of storefront services in the inner city and satellite clinics in rural areas, the sharing of psychiatric expertise with paraprofessionals, and a decreased emphasis on hospital treatment, with a concomitant emphasis on outpatient services and community-based alternatives to institutionalization.

It is as yet unclear whether these developments represent progress or merely another swing of the pendulum. There may be a lesson in the fact that whereas Dorothea Dix labored to get the mentally ill out of the community and into hospitals, we now labor to get them out of hospitals and into the community (8). What *is* clear is that many psychiatrists who are attempting to meet the challenge of the newer forms of service delivery feel inadequately prepared to meet the demands of the roles they have been pioneering. Most were trained in post-World War II models that tended to prepare psychiatrists for the practice of psychoanalytically oriented individual psychotherapy in solo office practice. Doubts about the utility of this training were soon reinforced by the criticisms of coworkers and of the intended recipients of their services. The validity of these misgivings and criticisms is not especially relevant here. What is important is that they served to focus attention on what psychiatrists do, what they should do, and how appropriately and adequately they are trained for their professional roles.

A host of influences has subsequently reinforced concerns about psychiatric training and the underlying question of what the potential psychiatrist is being trained for. While much of the stimulus for examining such issues has come from outside psychiatry—judicial critics, minority groups, the women's movement, government budget officials, etc.—psychiatrists themselves have become increasingly concerned with the question, "What is a psychiatrist?" As this is being written, an official body of the

American Psychiatric Association is attempting to provide an answer to this question.

Psychiatrists, like other professionals, are to a large extent what they have been trained to be, and they do in practice what they have been trained to do. But as delivery systems and emphases in psychiatric practice change, one can hope that the structure and content of training programs will be adjusted to better prepare residents for their changing roles. The study reported here was conceived as an attempt to provide certain baseline information about the nature and scope of the training offered in approved residency training programs. In focusing on the totality of residency training, this report and the parent monograph serve as companion pieces to an earlier APA publication (9) stressing the uniqueness of individual training programs. The data presented here are offered in the hope that they will facilitate answers to questions about the training psychiatrists should receive in the future by providing at least limited information about training and training programs in the immediate past.

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Short-Term Analytically Oriented Psychotherapy Versus Behavior Therapy

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Ninety-four outpatients with anxiety neurosis or personality disorder were randomly assigned for four months to a waiting list, behavior therapy, or psychoanalytically oriented therapy. The target symptoms of all three groups improved significantly, but the two treated groups improved equally well and significantly more than those on the waiting list. There were no significant differences among the groups in work or social adjustment; however, the patients who received behavior therapy had a significant overall improvement at four months. One year and two years after the initial assessment, all groups were found to be equally and significantly improved.

BEHAVIORAL TECHNIQUES are coming to be widely accepted in the treatment of monophobias, sexual impotence, and other "unitary" psychiatric problems; this acceptance is supported by a good deal of research. Gelder and associates (1, 2) showed that patients suffering from severe phobias tend to improve more quickly with behavioral than with psychoanalytically oriented or group therapy. However, in their studies this initial advantage was not maintained over time. Moreover, their research and that of others (3) have been criticized for failing to use experienced therapists for either modality.

Paul's study (4), which is often cited in support of behavior therapy, showed one technique, desensitization, to be clearly superior in treating unitary phobias among college students recruited as subjects; this superiority was maintained at follow-up (5). However, it is unlikely that the nature of these subjects' problems and their motivation for improvement are comparable to those of patients who spontaneously seek treatment. Similar criticisms as well as the use of inexperienced therapists apply in Di Loreto's comparative study of students with anxiety (3). In this study, desensitization clearly worked best, but this was because it was applicable to both introverts and extroverts.

Phobic patients, especially monophobic patients, are much rarer than patients with anxiety neuroses and personality disorders. There have been very few controlled evaluations of behavior therapy with patients with anxiety neuroses and personality disorders. The tendency has been to assume that only a "deeper" therapy could produce a lasting effect for these patients by attacking the underlying causes of general psychiatric problems.

Our aim in this study was to compare the relative effectiveness of behavior therapy and more traditional analytically oriented therapy conducted by experienced therapists with patients with anxiety neuroses and personality disorders. We also compared both therapies with the effect of an initial assessment interview plus the mere promise and expectation of help.

METHOD

Patients

Patients who applied for treatment at a university psychiatric outpatient clinic were initially seen by one of three experienced psychiatric interviewers (assessors). Patients who were below the age of 18 or over the age of 45, who seemed too mildly ill, or who were too seriously disturbed to risk waiting four months were excluded from the study. Also excluded were those who were psychotic, mentally retarded, organically brain damaged, or primarily in need of drug therapy. All others who wanted to have psychotherapy rather than drugs or some other treatment and for whom the assessor considered this to be the treatment of choice were accepted into the study. Twenty-nine applicants did not meet the criteria and were referred elsewhere or treated outside the study.

The 94 patients who were accepted were predominantly in their early 20s, women (60 percent), and white (only 7 were black). They had completed an average of 14 years of education (about 2 years of college or other post-secondary-school training). Over half of the patients were students, and about half were self-supporting. Roughly two-thirds suffered from psychoneuroses (usually anxiety) and one-third from personality disorders. The most frequent specific symptoms were, in de-

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creasing order, generalized anxiety; interpersonal difficulties, especially with the opposite sex; low self-esteem; generalized worry; and bodily complaints.

Psychological Tests

Mill Hill Vocabulary Scale: The mean intelligence quotient of the whole sample on this scale was 99.

MMPI. The overall means on this test showed a considerable degree of pathology in these patients. Four of the nine subscale mean scores (for depression, psychopathic deviate, psychasthenia, and schizophrenia) were within the abnormal range (above 70). The overall mean of the eight clinical scales was also in the abnormal range. Only 8 patients scored normally on all scales.

Eysenck Personality Inventory. The mean scores of the patients on this scale showed them to be introverted and neurotic at the 86th percentile of neuroticism.

California Psychological Inventory. The patients as a group showed lowered but not abnormal self-control, sociability, and socialization on this scale.

Assessment

One of three experienced psychiatrists saw each patient at the initial interview. These psychiatrists were not connected with the treatment. The patient and interviewer together drew up a list of three target symptoms—the major specific symptoms that had led the patient to seek treatment. Both the psychiatrist and the patient rated each target symptom on a 5-point scale of severity (6, 7). To judge the patient's general level of functioning, the Structured and Scaled Interview To Assess Maladjustment (SSIAM) (8, 9) was used. The SSIAM rates the patient's level of adjustment on 11-point scales for 10 items in each of the following five areas: work; social and leisure; sexual; and relationships with spouse, children, and family of origin.

These two measures, the list of target symptoms and the SSIAM, provided the main indices of change. In addition, a global impressionistic rating of overall improvement was made. Other measures taken will be reported separately.

Treatment

After interviewing and testing, the patients were randomly assigned in the following manner: 31 were assigned to behavior therapy, 30 to psychotherapy, and 33 to the waiting list. Within this random assignment, patients were matched within the three groups in terms of sex and severity of neurosis as assessed by the Eysenck Personality Inventory.

The Therapists

Of the three therapists in each group, one had more than 20 years of experience, one had 10 to 12 years of experience, and one had 6 or more years of experience. One was a Ph.D. psychologist and the other five were M.D.s. Two of the psychotherapists were psychoanalysts and a third was in personal analysis with a training analyst. All of the behavior therapists were formally trained. By using experienced therapists, we hoped to avoid the twin pitfalls of exposing a patient to an ineffective treatment (because a technique probably does not attain its full potential in the hands of a beginning therapist) and of biasing our results in favor of behavior therapy (where it is possible that less experience is required to attain a minimal level of competence than in psychotherapy) (10, 11). Each therapist treated at least 10 patients.

A list of stipulative definitions of each therapy was drawn up. This is presented in abbreviated form in appendix 1. This list outlined which procedures were common to both therapies and which were allowable only within one or the other modality. The therapists approved these definitions and felt that they would not restrict them in their respective treatments. Tranquilizers were discouraged; they were used very rarely in either treatment group.

Each behavior therapist used a variety of behavioral techniques, including systematic desensitization, assertive training, and avoidance conditioning, which he tailored to the needs of each individual patient. Similarly, the psychotherapists used various analytically oriented techniques of short-term insight therapy.

Analyses of the two therapies using a variety of rating scales and other questionnaire measures will be reported in detail elsewhere (12). These data verify that the two groups of therapists were using quite different techniques, had formed different types of relationships with their patients, and were in fact doing in therapy very much what they said they did.

Behavior therapy and psychotherapy patients received four months of usually weekly hour-long therapy (an average of 13.2 and 14.2 sessions, respectively). Fees were paid through the outpatient clinic according to its usual sliding scale.

Waiting List

The control patients were told that they would be placed in treatment but that because there were currently no openings in the clinic there would be a waiting period of no more than four months. During this waiting period they were contacted by telephone every few weeks by a research assistant, who asked how they were getting along and assured them that they had not been forgotten and would be placed in treatment as soon as there was a vacancy. They were also told that if there was a crisis they could call on the psychiatrist who interviewed them initially or the emergency unit of the department at any time. They thus received a moderate amount of nonspecific therapy that aroused hope, expectation of help, and the relief afforded by an initial interview.

Follow-Up

The patients were reinterviewed and reassessed by the original interviewers after four months and after one year. These assessors were blind as to type of therapy in most cases, but a few patients inadvertently gave clues to their therapist's identity.

The assessor rated the target symptoms as before on an absolute severity scale and on a comparative rating scale. He also made a rating of overall improvement.

TABLE 1
*Interviewer Ratings of Severity of Three Target Symptoms for 92 Patients at Initial Interview and Follow-Up**

Group	Rating at Initial Interview		Rating at Four Months			Rating at One Year		
	Mean	SD	Mean	SD	Significance**	Mean	SD	Significance**
Behavior therapy***								
Total group (N=29)	8.79	1.36	4.52	1.89	p<.001	3.83	2.59	p<.001
Patients who obtained no further therapy after four months (N=14)	8.85	1.66	4.85	1.99	p<.001	4.14	2.30	p<.001
Psychotherapy								
Total group (N=30)	9.13	1.65	5.27	2.70	p<.001	4.90	3.54	p<.001
Patients who obtained no further therapy after four months (N=21)	9.14	1.71	4.90	2.32	p<.001	4.24	3.18	p<.001
Waiting list								
Total group (N=33)	8.82	2.01	6.45	2.84	p<.001	5.45	2.95	p<.001
Patients who obtained no therapy after four months (N=14)	8.43	1.76	5.57	2.38	p<.001	5.29	2.77	p<.01

*The scores represent the sum of the severities of the three target symptoms, each rated on a 5-point scale (4=severe, 3=moderate, 2=mild, 1=doubtful or trivial, and 0=absent).
**Represents change from initial interview (by two-tailed t tests).
***The numbers represent the number of patients who had complete ratings on all three assessments.

Both patient and assessor rated work, social, sexual, and overall adjustment. The SSIAM was administered again.

A comparison of outcome ratings did not reveal bias by an assessor toward any group. Symptomatic self-assessments by the patients correlated well with the assessor ratings (r=.66 by Pearson product-moment correlation).

Two years after the initial assessment, a research assistant contacted as many patients as possible to rate target symptom severity and take SSIAM measures.

RESULTS

Four-Month Follow-Up

At four months all three groups had significantly improved on their three target symptoms (see table 1), but the psychotherapy and behavior therapy groups improved equally well and significantly more than those on the waiting list (see table 2).

Patients treated by behavior therapy improved significantly on both work adjustment and social adjustment (see table 3). Psychotherapy patients showed marginally significant improvement on work and no significant improvement in social functioning. Patients placed on the waiting list had significantly improved in social adjustment and marginally in work adjustment. However, analyses of variance indicated that the amount of improvement shown by the three groups was not significantly different either for work ($F=1.46$, $p>.10$) or social adjustment ($F=.55$, $p>.10$).

On a rating scale of overall improvement, 93 percent of the behavior therapy patients in contrast to 77 percent of the psychotherapy and waiting list patients were considered either improved or recovered ($\chi^2=3.93$, $p<.05$). Thus all treatments (including placement on the waiting list) were highly successful, but behavior therapy was significantly more successful in terms of the traditional global measure of improvement.

TABLE 2
Univariate and Multivariate F Values for Comparisons Among Treatment Groups and Control Group on Changes in Target Symptoms at Four-Month Follow-Up

Groups Compared	Univariate F Values			Multivariate F Value
	Symptom 1	Symptom 2	Symptom 3	
Behavior therapy versus waiting list	9.0148*	8.0513*	9.5708*	4.9292*
Psychotherapy versus waiting list	12.1725*	6.7628**	4.6018***	4.5742**
Behavior therapy versus psychotherapy	.2374	.0563	.9027	.5184

*p<.005.
**p<.01.
***p<.05.

The amount of improvement was independent of the sex of the patient, the amount of experience of the therapist, and the severity of the neurosis, except that the anxiety of women, especially those with high neuroticism scores, improved more than that of men.

A few patients whose initially reported symptoms had not improved in four months reported additional symptoms that were either new or had been too trivial to report at the initial interview. However, no patient in any group whose original problems had substantially improved reported new symptoms. Thus there was no evidence of symptom substitution.

One-Year Follow-Up

One year after the initial interview all three groups of patients had significantly improved symptomatically since their initial assessment (see table 1). The behavior therapy patients had improved significantly more on their target symptoms ($p<.05$) than the waiting list patients ($t=2.18$, $p<.05$), but the psychotherapy patients had not.

TABLE 3
Mean Scores on SSIAM Factors for Treatment Groups and Control Group at Initial Interview and Follow-Up

Group	Score at Initial Interview		Score at Four Months				Score at One Year			
	Work	Social Adjustment	Work	Significance	Social Adjustment	Significance	Work	Significance	Social Adjustment	Significance
Behavior therapy*										
Total group (N=29)	4.02	3.31	2.98	p<.001**	2.71	p<.05**	2.59	p<.001**	2.27	p<.001**
Patients who obtained no further therapy after four months (N=14)	3.98	3.56	2.79	p<.05**	2.64	p<.05**	2.54	p<.05**	2.73	p<.05***
Psychotherapy										
Total group (N=30)	3.42	3.10	2.85	p<.05***	2.72	n.s.	2.15	p<.001**	2.12	p<.001**
Patients who obtained no further therapy after four months (N=21)	3.07	3.15	2.67	n.s.	2.48	p<.05**	2.14	p<.05**	1.92	p<.001**
Waiting list*										
Total group (N=30)	3.49	3.52	2.81	p<.05***	2.78	p<.01**	2.85	n.s.	2.77	p<.05**
Patients who obtained no therapy after four months (N=11)	4.04	3.78	2.57	p<.05**	2.64	p<.05**	2.80	p<.05***	2.38	p<.05***

*The numbers represent the number of patients who had complete ratings on all three assessments.
**By two-tailed t tests.
***By one-tailed t test only.

These data excluded two behavior therapy patients whom it was impossible to interview. (They were informally known to have improved.)

Both treated groups were significantly improved on work and social adjustment at the end of one year, but the control group was no longer significantly improved on work adjustment (see table 3); there were no significant intergroup differences in amount of adjustment improvement.

However, after four months on the waiting list, 14 of the control patients no longer felt that they required therapy; those who did were assigned to senior residents, most of whom practiced analytically oriented insight therapy. In addition, many of those who had received treatment wanted and received small amounts of additional therapy, in most cases with their original therapists, between the four-month and one-year interviews. Thus 15 behavior therapy patients averaged a further 10.1 sessions and 9 psychotherapy patients averaged 19.3 sessions.

The varying amount and type of therapy between four months and one year tended to make comparisons between the original groups less valid than comparisons with those who received no treatment after four months. These latter patients, who did not differ from their total groups in any pretreatment or change measures, showed significant and equal symptomatic, social, and work improvement at one year (see tables 1 and 3).

Two-Year Follow-Up

Two years after the initial interview, 61 patients were interviewed by a research assistant. All groups had either maintained their status or continued to improve in all areas. Unfortunately, the psychotherapy patients who could be reassessed at two years proved to be those who had already shown the most improvement at one year. Because of this sample bias, a between-group comparison with the behavior therapy and waiting list patients, who were representative of their original samples, was not feasible.

DISCUSSION

There was very little difference between the two active treatment groups in amount of improvement, although it is tempting to argue that behavior therapy was somewhat more effective than psychotherapy. On a global measure of improvement, behavior therapy proved significantly better at four months than either psychotherapy or being on a waiting list. Moreover, behavior therapy patients had significantly improved on all three specific measures at four months, while psychotherapy patients had not improved in social adjustment.

At one year, patients originally treated by behavior therapy but not those originally treated by psychotherapy showed greater improvement than waiting list patients in reduction of the severity of target symptoms. The conclusion that behavior therapy is therefore more effective is tempered by the finding of no significant difference between groups in the amount of improvement in social adjustment and the fact that the one-year comparison of the two groups was confounded by treatment after four months. We conclude that there is no clear evidence for the superiority of behavior therapy over psychotherapy.

However, behavior therapy is clearly a generally useful

treatment. Both active treatments were found effective in treating specific symptoms and in improving the patient's reported ability to cope with life. Our data do not support the view that although behavior therapy may have a short-term or limited value in dealing with specific symptoms, only deeper and more analytic treatment can produce general change in the patient by treating the underlying causes of symptoms as well as the symptoms themselves.

CONCLUSIONS

Behavior therapy produced significantly more overall improvement at four months than psychotherapy. However, this is a very general subjective measure and there was no significant difference between psychotherapy and behavior therapy on any other measure at any other time.

At four months both treated groups had improved significantly more than the waiting list group on target symptoms but not in general adjustment. This is impressive in view of the great improvement shown by patients receiving the minimal treatment of placement on a waiting list.

All groups improved in general adjustment, but at four months this improvement was clearly significant only for the behavior therapy and control groups.

At one year, behavior therapy patients but not psychotherapy patients showed significantly more symptomatic improvement than did control patients. However, this result may be confounded by the fact that differing amounts of further treatment were given after the four-month study period. There were no differences between those who received no further treatment after four months.

All groups maintained or continued their improvement between four months, one year, and two years regardless of whether or not further treatment was received during this period.

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APPENDIX 1

Techniques Characteristic of Behavior Therapy and Psychotherapy

CONTRASTING ELEMENTS

Specific advice is given frequently by behavior therapist; given infrequently by psychotherapist.

Transference interpretation is avoided by behavior therapist; may be given by psychotherapist.

Interpretation of resistance is not used by behavior therapist; used by psychotherapist.

Report of dreams: behavior therapist shows polite lack of interest; psychotherapist may use in treatment.

Relaxation training is directly undertaken by behavior therapist; occurs only as an indirect consequence of a relaxed atmosphere in psychotherapy.

Desensitization is directly undertaken by behavior therapist; occurs only as an indirect consequence of discussing problems in a relaxed atmosphere in psychotherapy.

Practical retraining is directly undertaken by behavior therapist; not emphasized by psychotherapist.

Assertive training is directly undertaken and encouraged in everyday life by behavior therapist; only indirectly encouraged in everyday life by psychotherapist, but assertive or aggressive speech permitted in psychotherapy session.

Report of symptoms: interest is shown by behavior therapist, who may explain them biologically; discouraged by psychotherapist, who may explain them symbolically.

Childhood memories: behavior therapist usually takes history as such; psychotherapist usually looks for further memories.

Aversion (e.g., electric shock) may be used by behavior therapist; not used by psychotherapist.

Role training may be used by behavior therapist; not used by psychotherapist.

Repetition of motor habits may be used by behavior therapist; not used by psychotherapist.

ELEMENTS IN COMMON

Both therapists may take a biographical psychiatric history; formulate the patient's problems; attempt to reconstruct possible original causes of the disorder; look for continuing causes of the difficulty; aim to produce a change that benefits the patient, such as reducing subjective complaints or behavior that disturbs the patient or others; correct misconceptions; elucidate objectives; and attempt to change others, e.g., family, employer, doctor.

Psychotherapy: Historical Roots, Universal Elements, and Cultural Variations

BY WEN-SHING TSENG, M.D., AND JOHN F. MCDERMOTT, JR., M.D.

The authors review various forms of traditional psychotherapeutic interventions to trace the historical development of psychotherapy, which demonstrates a shift in focus from the supernatural world, to the natural world, to the physical person, then to the psychological person. The basic processes of identifying problems, providing explanations, and prescribing for change are observed among various kinds of treatment systems. Universal elements fundamental to successful treatment can be identified in each of these processes, and each is strongly modified by cultural factors. The authors conclude that the special cultural dimension of psychotherapy consists of defining cultural norms, reinforcing culturally sanctioned coping mechanisms, and providing "time out" from usual cultural expectations.

HUMAN BEINGS have encountered psychological problems since ancient times. We have learned to cope with them by devising various forms of healing practices. In modern terminology these practices may be broadly conceived of as psychotherapeutic variations. Since there seems to be a revival of popular interest in the occult as well as scientific interest in Chinese medicine and traditional healing practices today, it may be appropriate to attempt an analysis and synthesis of these varieties of healing practices as they relate to modern Western forms.

In this paper we will attempt to trace the development of the earliest forms of psychotherapeutic intervention that still predominate today in the major populations of the world; describe the universal elements that appear to be common to all psychotherapeutic varieties; and discuss the cultural variations in psychotherapeutic approaches based upon differences in referential systems and sociocultural settings, which dramatically determine the degree of effectiveness and relevance of psychotherapy.

It is becoming more and more clear that such simplistic notions regarding therapeutic approaches as considering one approach universally primary or superior are no longer tolerable. Many techniques seem to be effective with the same problems throughout the world. Thus the following questions arise: How do various therapies relate to each other? What components do they share? Which cluster of components works best with which people? Why?

The purpose of this study is to broaden our understanding of the basic nature of psychotherapy and to increase our knowledge of how to apply psychotherapy more effectively and relevantly in different sociocultural settings.

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HISTORICAL PERSPECTIVE

The traditional forms of healing practices outlined below persist today. They are described to provide a basis for further consideration of the universal characteristics of a broad conception of psychotherapy.

Shamanism

Shamanism is characterized by the belief in the existence of the supernatural. It is assumed that a special person—the shaman—has the power to communicate with spirits and to use supernatural powers to solve clients' problems. Through a religious ceremony a shaman can work himself into a trance state in which he is "possessed" by a supernatural power. The client can then consult the supernatural through the shaman for instructions in dealing with problems (1).

The causes of problems are usually perceived and interpreted by the shaman as having to do with object intrusion, loss of the soul, sorcery, spirit intrusion, or violation of taboos (2, 3). By interpreting for the client the idea that a god, a devil, or a soul is the potential source of interference, the shaman provides a conceptual enemy and a concrete object to cope with. The coping methods suggested by a shaman are usually magical in nature, e.g., prayer, the use of a charm, or the performance of a ritual ceremony for extraction or exorcism.

Divination

Divination varies from shamanism in that an attempt is made to obtain divine instruction through occult means. It is believed that there are certain principles and ways of life which are regulated by a supernatural power. The occurrence of any problem is understood as the result of opposing these principles and ways of life. The purpose of divination is to find out exactly which principles and way of life to follow (4–6).

Clients who practice divination believe in a supernatural being, a god. They depend on supernatural powers for solving their problems. However, since the inter-

pretation of divine instruction is usually assisted by an interpreter, the interaction between the interpreter and the client becomes an important variable. The effectiveness of this form of therapy may therefore depend upon the experience and other qualities of the interpreter.

Fortune-Telling and Astrology

The system of reference shifts from the supernatural to the natural in fortune-telling and astrology. The assumption that underlying principles of the universe rule nature—including human life and behavior—is the basis of this form of therapy. The concepts of microcosm and macrocosm are present.

The nature of a problem is explained as the result of an imbalance or disharmony with the underlying natural principles that rule the universe. The objective is to help the client find out how to live compatibly with nature and adjust to the environment more harmoniously and with a greater degree of stability. Again, the interaction between the fortune-teller or astrologist and the client is an important variable in the effectiveness of the therapy.

Physiognomy

In physiognomy the practitioner (physiognomist) reads signs that relate to the given problem from the client's face, skull, or palm. These parts of the body tell the story of the client's character and life patterns; advice in managing life's problems emerges from this knowledge. The focus of concern shifts from the supernatural or the natural balance of things to the client himself. This system views problems as originating from certain predispositions in the individual.

The essence of the treatment is to let the client know more about himself and his predispositions so that he can live with what he is and make use of the assets he has. In a way, a physiognomist is a folk psychologist who provides consultation for the personality based on an interrelationship between the body and the mind.

Physiologically Based Treatment Systems

Treatment systems based on physiology relate problems to a disequilibrium, insufficiency, or decompensation of the individual's physiological system—particularly the nervous system. For example, mesmerism hypothesized that a shortage of special magnetic fluid was the cause of mental illness; the treatment of neurotic phenomena was therefore to supply this fluid.

Supplementation of deficiencies, recuperation, and compensation are the methods generally employed in this system, although suggestion is an important variable in the healing process. Rest therapy, part of Japanese *morita* therapy (7), requires patients to take absolute bed rest for several days. This therapy is based on the assumption that the patient is suffering from an asthenic condition of the nervous system that requires rest and recuperation.

Sociopsychologically Oriented Treatment Systems

Much of modern psychotherapy is sociopsychologically oriented: emotional problems and mental illness are viewed as psychological reactions to the stress of internal conflict or external maladjustment. The essential core of this therapy is that the client, with the assistance and support of the therapist, solve the problem. This is the basis of individual, group, insight, behavior, short-term, and long-term modern therapy.

It is obvious that among various forms of mental treatment there is a shift of focus from the supernatural, to the natural, to the physical person, and then to the psychological person. This progression suggests that both theory and practice, in all their variations, may have developed historically in this sequence (8–10).

UNIVERSAL ELEMENTS IN ALL PSYCHOTHERAPIES

In spite of the fact that they differ in referential systems and styles of approach, all of the various forms of psychotherapy share certain conditions. For example, in the practice of each therapy there is the presence of a healer, who supposedly possesses a superior ability to help others, and a client or patient, who is seeking help from the healer to solve his problems. Furthermore, all therapies attempt to influence the patient in three areas—cognitively, emotionally, and behaviorally—even though some emphasize one area much more than the other two.

Basic Operation

From a conceptual point of view the operation of psychotherapeutic intervention can be described as a series of stages or phases that overlap and vary considerably in emphasis and length, depending on the particular technique being considered. The stages are as follows: identification and analysis of the problem, explanation of the problem and the setting of goals, prescription for change, establishment of a working relationship, implementation of the prescription for change, and termination.

In the early phase of treatment the work of identifying and analyzing the problem takes place. When a person encounters stress, he needs to alleviate his anxiety by learning the nature of his problem and how to cope with it. The identified problem becomes the enemy (11). No matter what kind of enemy is identified or diagnosed—disturbance made by a devil, breaking a taboo, imbalance of vital powers, deprived childhood experiences, or schizophrenic disorder—the client's anxiety is usually decreased by knowing that the therapist is able to identify and name the problem. Based on the "principle of Rumpelstiltskin," the very act of naming the problem has a therapeutic effect (12). Furthermore, the client is more likely to become actively involved in an attack on an identified problem.

Associated with the process of searching for the cause of the problem, there follows the stage of explanation or interpretation of the nature of the problem to the client. No matter what kind of language—magical or rational—is used, there are always sociopsychological therapeutic implications in the interpretation. For example, the view that witches are to blame for misfortune not only provides concrete personification of the cause, making

it possible to initiate action for coping with the enemy, but also encourages externalization of anger and drains off in-group hostilities, promoting a kind of social integration (13). The interpretation that an ancestor's spirit is resentful of being neglected and has therefore caused the client's illness may actually imply to the client that there is a need to improve intrafamily relationships in his real life.

The stage of prescribing the treatment to remedy the client's problem follows the process of explanation. Again, no matter what kind of suggestion is prescribed for the client—exorcism, regulation of his life, supplementation of vital powers, relearning of habits, or expression of repressed wishes—the giving of the suggestion itself usually supplies hope and cultivates motivation for the client to cope with the problem (14). The prescription of treatment may also help the client to choose the best course of action from among several possible alternatives.

In the middle phase of therapy, which includes the stage of implementing the treatment, behavioral components begin to replace cognitive and emotional ones: knowledge is put into practice. The therapeutic activities end in the stage of termination, when the client has accepted a mutually satisfactory balance of mastery over some problems, adjustment to others, and the acceptance of the problems that continue to be present.

Core Elements of Psychotherapy

Just as a fish never realizes the importance of water unless he comes out of it, the core elements or existing essence of any form of psychotherapy is seldom recognized unless the practice of therapy has to be performed in a radically different sociocultural setting with remarkably different kinds of clients. The core elements of psychotherapy can be defined as follows:

1. *Orientation to the healing system.* Imagine a shaman who is invited to practice his healing ceremony in a highly industrialized society for a client who has never had the opportunity to learn or accept shamanism, or an analyst who is asked to practice analysis in a primitive village in which the people have never been oriented to this treatment. We can then better imagine how the client's orientation to the healing system becomes a crucial factor in the outcome of therapy.

It is likely that the extent to which the client is familiar with and oriented to the treatment procedure will largely determine its effectiveness; the client's expectation and beliefs will be influential factors (15–19). Modern behavior therapy may be most useful for those who are oriented toward simple, concrete, clear-cut approaches to understanding and dealing with their problems. It may be most appealing to those who are impressed by scientific evidence from the laboratory or outcome data—the symbols of modern magic.

In a similar way, faith healing may be most helpful to those who are accustomed to dealing with problems in a supernatural, abstract way. It may also be attractive to those who tend to be influenced by supernatural beliefs and who have problems that could not or should not be totally understood and mastered. Thus there is a kind of preexisting factor in the individual within his cultural setting that influences the appropriateness and chance of success of a particular therapeutic modality.

2. *The personality of the therapist.* This factor is often neglected. It is considered somewhat embarrassing, particularly to Western therapists, to consciously accept a charismatic or authoritarian role. The fact that personality factors are less available to influence by training than are techniques is also disconcerting. However, the personality of the therapist is important because it is the vehicle or instrument through which the technique—whatever it might be—is applied.

Personality qualities have traditionally been considered to include such things as concern for the patient, sensitivity toward each patient (i.e., having "X ray eyes" or the ability to think and feel as the client does in order to communicate effectively), an expectation of success related to the influence of the therapist's own personality, and a benevolent but authoritative attitude.

It is highly likely that in the comparison of successful with unsuccessful healers practicing various kinds of healing techniques, we would find that in addition to the differences in theoretical orientations and technical approaches, the healer's personality is a crucial factor that makes him more successful or less successful regardless of culture (18, 19). Thus a successful shaman, fortune-teller, or modern therapist may have similar skills in relating to other people and in knowing how to maintain socioculturally relevant therapist-client relationships so that he can function with his technique with maximum effectiveness.

We often see young therapists wedded to a particular technique, believing that the techniques they have learned are the most important factor in the improvement of their patients. As they mature, however, they begin to become more flexible in their use of that technique; they realize the influence of their own personality as its vehicle.

3. *Scenery for a therapeutic operation.* Successful drama needs an appropriate theater with a suitable stage for its performance. Similarly, a successful healing operation needs an appropriate therapeutic atmosphere. If a shaman is not allowed to dress in his special garments or to perform his dramatic ceremony to reinforce the client's belief that he is possessed by a god, he may fail. If the Chinese fortune-teller does not carry a turtle shell—the symbol of ancient knowledge and an archaic instrument for divination—he may not impress his Chinese clients. If a Gypsy fortune-teller does not have a crystal ball, she may be without the necessary prop to complement or reinforce her therapeutic performance. Even the modern psychotherapist needs his license or certificate, sometimes displayed prominently on the wall, photographs of the fathers of his school of therapy, suitable furniture, and an appropriate office or hospital setting. However, modern Western therapists prefer to minimize the significance of this therapeutic scenery and to neglect it, at least consciously, in their work.

CULTURAL VARIATIONS IN PSYCHOTHERAPIES

Many psychiatrists are developing an increasing interest in the study of culture as it relates to psychiatry, particularly since Eastern approaches have become better known in the Western world. The particular society and culture determine not only how symptoms of emotional disorder are defined but in many cases how they should be treated.

Defining the Cause of the Problem

The process of analyzing and identifying the nature of the problem in the process of psychotherapy has been described as a game of hide and seek (20). In order to bring to a conscious level conflicts and resistances that have remained unconscious in the patient, the "game" of analysis can take place in various forms.

In different treatments and places, various forms of special experiences have been used to explore, reveal, and express the nature of the client's problem. For example, among the Iquitos of Amazonian Peru, the healing vine, a powerful hallucinogen, is used by the healer to induce hallucinations. Using the content of these hallucinations, the healer can discover who is responsible for the client's illness (21). A shaman often induces himself into a trance state in which it is presumed that his perception of the nature of the client's problem can be increased and sharpened.

In Korea, Taiwan, and Singapore, a shaman can be possessed by the spirit of one of the client's deceased relatives. This is done with the client's permission and enables the client to communicate with the deceased family member to explore and reveal the nature of the trouble occurring in his family (22, 23). A widow may discover just how her husband was killed in an accident and thus resolve doubts that had been bothering her for a long time; a mother who misses and worries about her deceased daughter may be comforted to learn that she is living happily in another world. Thus the special experiences of the healer may help the client expand the areas in which he can search for an answer.

Other treatment methods provide for the client to engage in the game of searching for the answer to his problem. In ancient Greece, the client went to the temple to experience a divine dream after a purification ceremony. The nature of his problem could be analyzed and understood by an interpreter on the basis of the content of the dream (24).

In one form of Japanese folk healing, the client works himself into a trance state as if he were possessed by a god. Under these conditions the client can then speak and behave as his other self, i.e., in the name of the god who possesses him (25). He can thus express complaints or unfulfilled wishes that would be difficult or inappropriate to express in his usual life situation. The practice of such spirit possession sanctions the expression of behavior that is otherwise socially unacceptable or unavailable.

In the initial stage of Japanese *morita* therapy, neurotic patients are deliberately ordered to go through a rest period (7). During this rest the patient experiences stimulation deprivation for one week. He leaves his ordinary daily life, confines himself in an isolated room, and is restricted in both mental and physical activity. Through such a retreat from his daily life the client is provided an opportunity to examine himself from a position that he is unlikely to enjoy in his busy daily life. Theoretically, after this examination of his desires, motives, and behavior patterns, he will be able to find better ways to cope with his problems.

No matter what kind of experience is used in the process of searching for the secret of the problem—drug-induced hallucinations, ritually induced trance states, dreaming, possession, retreat from reality into an ancient folk practice, projective psychological tests, or free association—special experiences provide the opportunity for the client to examine himself and the situation and facilitate the search for the cause of his problems.

In the game of searching for the answer, the healer and client play different roles in the traditional forms of therapeutic practice than they do in modern therapy. In shamanism, the client is expected only to specify what problem he is seeking help for. The healer is expected to use his divine power to discover the secret and to analyze the nature of the client's problems himself. This task is heavily dependent on, among other factors, the healer's instinctive sensitive perception and accumulated personal experience.

While traditional methods place most of the responsibility for finding the secret or answer on the healer, modern psychotherapies consider the patient to have a major responsibility in providing detailed information about himself and his life so that the nature of his problems can be discovered and a solution can be found.

Explanation of the Problem

The explanation given for problems varies greatly among the various psychotherapies and reflects the historical evolution of concepts of mental illness (26). The interpretation of the nature of psychiatric problems has shifted from supernatural to natural and from biomedical to sociopsychological along with the increase in knowledge and gradual evolution of theoretical systems of reference.

However, different societies will always tend to shape the interpretation of problems according to their own inherent sociocultural characteristics (27). For example, in agricultural societies, in which harmony with nature is the essence of survival, disharmony with the environment is considered an important cause of psychiatric disturbance, while in hunting societies, in which conquest and competition are highly valued, conflict and antagonism will be seen as important reasons for problems.

Similarly, if the pattern of life of a particular group of people is characterized by hypochondriacal tendencies, that society may interpret illness on the basis of insufficiency or weakness. A group of people who are characterized by obsessional tendencies may tend to consider disordered behavior as the cause of all problems and em-

phasize guilt in their resolution. A society concerned over sexual matters may interpret most problems according to their sexual overtones and undertones. Those who value interpersonal relationships in their society may tend to explain problems according to disturbance in interactional processes.

Rather than a right-or-wrong, either/or etiological understanding of problems cross-culturally, we must expect variations according to these factors. It is most important that the explanation of the problem is familiar and culturally meaningful to the client so that he will accept it and work within the framework of the solution suggested. To explain to a Chinese woman that she is possessed by a male tiger that has caused her to be aggressive and cruel to her husband is more relevant than identifying her as a phallic woman castrating her husband. On the other hand, to interpret to an American husband that his difficulty with his wife is due to the fact that he was born with a fire nature while his wife has a water nature and that therefore they are poorly matched will not likely be very helpful to him. From the cultural point of view, the content and language of the explanation should be relevant, meaningful, and understandable to the client.

However, from another point of view the content and explanation may also need to have something unique, a quality of being special in either supernatural or scientific terms. This quality makes the explanation slightly different from the ordinary explanations available in daily life. Magical factors in an explanation can maximize treatment effectiveness. Such factors may vary from technical psychodynamic explanations of learned maladaptive behavior to supernatural explanations of demons and devils, as long as they provide new discoveries for the client.

Prescription for Change

The therapeutic approach prescribed by a healer is logically related to his underlying theoretical system. Thus exorcism will be suggested for intrusion; regulation of life will be encouraged for a disorder of rhythm; supplement of energy and vitality will be prescribed for insufficiency of vital powers; and relearning will be scheduled for learned maladaptive behavior.

Furthermore, cultural factors strongly influence the selection of treatment methods. One anthropological study (28) revealed that sacrifice or blood letting to relieve guilt was often used in societies in which aggressive behavior had been strictly prohibited for children. The choice of therapeutic practice is related to the predominant personality patterns of the society concerned.

Even the same problem will have a wide variety of solutions in different sociocultural settings. In a Taiwan village, for example, the "ghost marriage," a special marriage practice, is occasionally prescribed by a shaman as a way of solving the problem of family conflict (29). If a client consults a shaman for frequent illness or other problems in his family, the problems may be interpreted as caused by a deceased unmarried female, the ghost of whom the man must marry to solve the family problems. This practice is based on the fact that according to the Chinese clan system a girl who dies in childhood is excluded from the family clan. Thus a "marriage" will help the deceased girl to find a proper clan position in a family—an important matter for the Chinese. Furthermore, from a psychological point of view, such a marriage with a female "ghost," usually his wife's deceased sister, may fulfill and control the man's polygamic wish, regulate the husband-wife relationship, and thus restore the family functioning. This form of healing can be practiced in a society that values and emphasizes the family clan system.

In the United States, the Hawaiian people have had a traditional healing practice for family conflict, *hooponopono*. The term *hooponopono* literally means "to make things right." The tradition is that all of the members of the extended family are asked to get together by the head of the family if there is a serious family conflict. After a ritual prayer to the gods asking for assistance in solving the problems, the family members who are involved in the conflict are asked to present their complaints directly and openly. After discussing and confronting each other's intentions and motivations for their behavior, it is expected that one person will admit guilt and apologize for his "wrong" behavior. If the person who has been wronged is willing to accept the apology, the family conflict is then expected to cease. The family members then go to the shore and give back to the sea everything they have discussed so that it will not be left to affect them later. The meeting is finally closed with a banquet celebration so that the family can function normally again.

The explicit identification of wrong and right persons and the procedure of admitting guilt and making apologies in a well-defined ritualized manner was a useful practice in a society in which concrete communication is valued.

Japanese *nai-kan* (introspective) therapy (30), a form of psychological treatment that has been practiced in Japan for the past 30 years, is characterized by the client's meditating continuously according to a highly structured series of instructions emphasizing self-observation and self-reflection. During the meditation the client is asked to examine himself in relationship to others, usually his family. He is instructed to recall the care and benevolence that he has received from others, what he has returned to them, and what troubles and worries he has given to them. Improvement is supposedly brought about by an increase of real feelings of gratitude toward his family and increased awareness of his responsibility for his social role. This treatment strategy is most useful within a cultural context that emphasizes and values feelings of gratitude.

In contrast with this, modern Western family therapy emphasizes independence, speaking out, improved communications, and expression of resentment and suppressed anger. Thus methods for solving family conflict vary—whether through the process of interfamily member confrontation and communication, emphasis on the individual's increase of positive feelings toward other family members, or the use of special marriage practices —according to the sociocultural setting.

CULTURAL IMPLICATIONS OF THERAPEUTIC ACTIVITIES

In view of the enormous variation in psychotherapeutic practices in different sociocultural settings, it is pertinent to raise questions about therapeutic activities from a cultural point of view (31). The cultural meaning of psychotherapy can be understood in the following ways:

Defining norm, value, and goal for the client. From a cultural point of view, one of the important functions of psychotherapy is to help the client to define norms, establish a value system, and achieve a philosophy of life. Although mental health implies a mental condition of maximum efficiency, happiness, and success in an individual's adjustment to his environment, the terms "normal," "healthy," and "success" are defined by the sociocultural system. Thus one purpose of psychotherapeutic activity is for the therapist to function as a representative of the values of his society. The therapist fills the combined role of priest, judge, and physician to help the client find an appropriate value system (32).

In traditional forms of healing or folk counseling, the therapists are very confident and active in imposing their values and goals on the client (33). The shaman and fortune-teller are by definition superior persons; they do not hesitate to communicate their values to the client. Modern therapists tend to minimize or deny the fact that they impose values on the client. However, no matter how neutral the therapist claims to be, his response is still based on an implicit personal value judgment. Most clients consult a healer in order to seek answers and to define values and goals in their lives.

Reinforcing socioculturally sanctioned coping mechanisms. The function of psychotherapy is often considered not only to define norms, values, and goals for the client, but also to reinforce socioculturally sanctioned behavior. This is well exemplified by Chinese divination. An analysis of this form of therapy (34) showed that the majority of the advice given clients suggested that the client be satisfied with what he is, that he remain conservative and traditional. The client is usually warned not to be too aggressive or ambitious or to do things that are inappropriate for his role and status. The client is told to maintain the situation and that it is not good to try to change or to move. This reinforces the traditional Chinese way of remaining patient and unaggressive, to accept the situation rather than to rebel against it. This social behavior has been culturally relevant and adaptive (34).

In Japanese *morita* therapy, which is based on the philosophy of Zen Buddhism, the therapist advises the client to be *arugamama*—to take reality as it is, accept it, and live with it (7). This is an attitude of facing the problems and symptoms in one's life without struggling to evade, escape, or deny them. Acceptance is the basic philosophy of life—commonly misunderstood in Western culture as passivity. It is not merely passivity or even resignation, but a clear recognition of a given situation and the courage to embrace and live with the reality.

In the case of a neurotic person, particularly one with hypochondriacal or neurasthenic tendencies, the individual is thought to be absorbed in his own egocentric narcissistic concerns to the point that he has forgotten about the happiness, contentment, and inspiration that others find in nature. *Morita* therapy therefore emphasizes giving the patient access and time to be with flowers, vegetables, trees, etc., to open a channel toward nature and at the same time to his natural self. This treatment makes use of the Japanese life attitude of being *arugamama.*

A basic principle of Western client-centered therapy is to minimize the amount of advice, interpretation, and environmental manipulation that the therapist gives. The purpose of these restrictions is to prevent the therapist from arbitrarily imposing his values on the patient. Although this theory may reflect the fundamental distrust of the expert in American culture, it is actually aimed at reinforcing the American ethos that all men are basically equal and should function independently (35). In other words, client-centered therapy reinforces a coping mechanism that is valued in American culture—learning to solve problems by oneself.

No matter what kind of therapeutic activities are performed, the treatment tends to reinforce the socioculturally sanctioned coping mechanisms, even though such coping mechanisms may vary greatly in different cultural settings.

Providing permission and opportunity for sociocultural "time out." Another function of therapy is to provide permission and opportunities for the client to have time out from the sociocultural system. The cultural time out can take effect in various ways. The therapeutic process known as catharsis gives a client the opportunity to express socioculturally forbidden desires or feelings during the therapeutic session. By going into a possessed trance state, a client is given the chance to play his "other self," to act out or complain about anything that he is usually not allowed to do in ordinary life (25). Within a society in which self-sufficiency and responsibility are highly idealized, it is often difficult to find opportunities for the satisfaction of dependency needs except in a therapeutic setting. Here it is provided under the guise of sickness and with the purpose of understanding oneself (36). In contrast to this, in a society in which dependency is allowed and which is characterized by overcrowded interpersonal intimacy, time out may be needed in the form of meditation or social isolation as an opportunity for obtaining relief. The kind of time out for the client varies with the pattern of life from society to society.

CONCLUSIONS

While modern psychotherapists are interested in studying therapeutic technique and are busy trying to discover and develop more specific ways of treatment for specific problems, it may also be useful for us to learn the universal elements fundamental to successful treatment that are common to all psychotherapeutic activity. It is also important that we be sensitive to and aware of the cultural variations of psychotherapy that make the treatment

relevant and effective in different sociocultural settings. By considering how human beings have learned to cope with psychological problems through various forms of healing practices in different times and in different places, our concepts of psychotherapy may be usefully broadened and our treatment skills improved.

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Short Versus Long Hospitalization: A Prospective Controlled Study. II. Results for Schizophrenic Inpatients

BY IRA D. GLICK, M.D., WILLIAM A. HARGREAVES, PH.D., MARJORIE RASKIN, M.D., AND S. JEROME KUTNER, PH.D.

The authors compared treatment results for 141 schizophrenic patients randomly assigned to short-term or long-term hospitalization. The patients received intensive treatment and were on partially fixed drug dosage schedules. Test results indicated that the short-term group was functioning better at four weeks. However, at discharge (21 to 28 days for short-term patients; 90 to 120 days for long-term) the long-term group showed significantly better functioning. There were no significant differences between the groups on symptomatology at discharge. The authors discuss the implications of these findings for decisions regarding length and type of hospitalization for schizophrenic patients.

THIS STUDY ADDRESSES the question of the relative clinical cost-effectiveness of short-term hospitalization (defined here as 21 to 28 days) as an alternative to long-term hospitalization (90 to 120 days) for schizophrenic patients in need of hospital care for whom both types of treatment are judged clinically feasible. We previously reported the preliminary results of a one-year follow-up of the first half of a study group of 141 schizophrenic subjects (1). In this paper, we will report the results of the inpatient phase of the study involving the entire group.

BACKGROUND

In our previous report (1), we reviewed the literature, noting that there have been virtually no controlled evaluations of alternative methods of hospital treatment for acute episodes, i.e., brief versus extended in-hospital stay. The previous study that is most relevant and comparable in design to our work was a Veterans Administration multihospital study by Caffey and associates (2). (We discussed differences between their sample and methods and ours in our earlier report.) An interesting finding of that study was the tendency of short-term patients to be less symptomatic at discharge than were the long-term patients at a comparable time after admission. The present study was designed in part to assess this apparent symptom suppression effect of short-term treatment in a study in which both length of stay and drug treatment were more carefully controlled than they were in the Coffey and associates study.

Revised version of a paper read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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METHOD

Subjects

All patients consecutively admitted to the Clinical Research Ward of the Langley Porter Neuropsychiatric Institute during a 26-month period (N=255) were randomly assigned to either short-term or long-term hospitalization. This paper reports on the 141 schizophrenic patients (71 short-term and 70 long-term) who fitted all of the selection criteria used in the National Institute of Mental Health (NIMH) multihospital study of phenothiazines (3) except that of length of previous hospitalization. The NIMH study required subjects to have been out of the hospital for 12 months. This was not possible with our sample because many patients who were referred for admission had had some recent hospitalization. Our working guideline, however, was to limit admission to patients who had been hospitalized for a total of less than 7 days in the 2 months prior to admission. Since this was not always possible, we did a separate analysis (described later) of a selected sample to partially correct for this factor. Three patients (1 short-term and 2 long-term) diagnosed as schizophrenic on admission who left the hospital against medical advice less than 72 hours after admission were not included in the total of 141 study subjects.

Demographic Characteristics

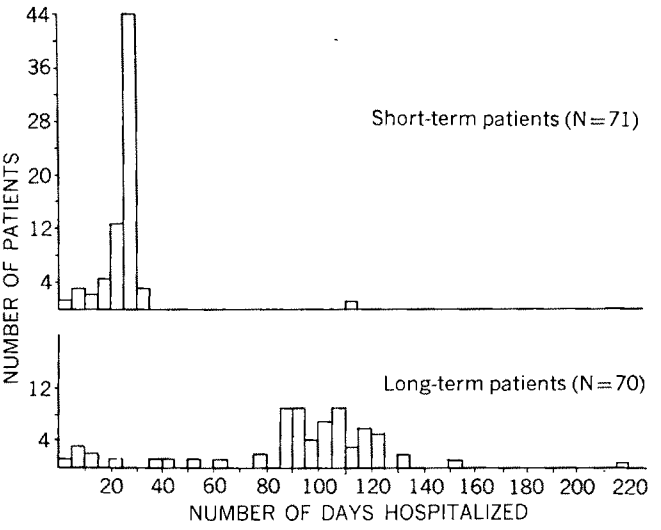
The demographic characteristics of the sample are presented in table 1. There were no significant differences between the long-term and short-term groups vis-à-vis

TABLE 1
Demographic Characteristics of the Sample (N=141)

Item	Treatment Group	
	Short-Term	Long-Term
Sex		
Male	37	42
Female	34	28
Marital status		
Single	53	55
Married	12	6
Divorced or separated	6	9
Race		
White	50	57
Black	11	9
Other	10	4
Age (in years)		
Mean	23.2	24.5
SD	5.3	6.2
Education (in years)*		
Mean	12.1	13.1
SD	2.5	2.0
Socioeconomic status**		
Mean	3.8	3.3
SD	1.0	1.0
Premorbid adjustment***		
Mean	6.0	5.2
SD	2.3	2.2

*$p<.05$.
**Measured on a 5-point scale. Significantly different ($p<.01$).
***Measured on a 13-point scale. Significantly different ($p<.05$).

FIGURE 1
Number of Days of Hospitalization for Patients in Short-Term and Long-Term Groups



sex, marital status, race, or age. However, despite random assignment, the long-term group had significantly more education ($p<.05$), higher socioeconomic status ($p<.01$), and better premorbid adjustment ($p<.05$).

Treatment Setting and Assignment

We described the treatment setting and random assignment procedures in our previous report (1). All patients gave informed consent and were aware of their treatment assignment within an hour or so of their admission. The actual length of stay for the two groups is shown in figure 1. We achieved a marked separation in the average length of stay, although there is the expected overlap from patients in both groups leaving the hospital against medical advice (thus leaving early) or not leaving when scheduled because they were considered to be at high risk for suicide or homicide.

Treatment Program

We have previously described the treatment program for the two groups (1). During one 3-month period in the middle of the project, we measured and described the types and lengths of treatment received by short-term and long-term patients by means of direct observation and questionnaires filled out by the treatment staff and patients. The results of this assessment are summarized in table 2.

A partially fixed drug regimen was used with patients from both groups in an effort to use similarly high phenothiazine levels during their early weeks in the hospital, regardless of length of stay. This was successful in that there were no clinically or statistically significant differences between groups in the amount of medication received on any of the first 21 days of hospitalization. After that, high phenothiazine levels were prescribed, as was the case in our previous report (1).

Evaluation

Both treatment groups were assessed at admission and at their respective discharge times. In addition, the long-term group was assessed 4 weeks after admission, a time that corresponds to the modal short-term discharge point. Patients were assessed on a variety of measures to compare prehospital, hospital, and posthospital course. Only the two evaluation instruments used to measure the inpatient phase are described here.

The Health-Sickness Rating Scale (HSRS) (4) is a global rating of psychiatric functioning. Ratings are on a scale of 0 (severely disabled) to 100 (very effective functioning), and brief descriptions of various levels of functioning serve as rating anchors. Each patient was rated independently, usually by two staff psychiatrists, using all the clinical and research data available. These raters knew the patients' treatment assignments. If the ratings differed by more than 10 points (on a scale of 0 to 100), the differences were discussed and ratings were changed until they agreed within 10 points. The averages of these adjusted ratings were used in the data analysis.

Not all patients were rated by the same two staff psychiatrists. Therefore, reliability was determined by correlating the original ratings (i.e., before discussions) for each pair of raters at each time period. There were 11 product-moment correlations, with sample sizes ranging from 23 to 162 (nonschizophrenics were included); the correlations ranged from .42 to .78, with a median of .57,

TABLE 2
Description of Psychosocial Treatment Program for Short-Term and Long-Term Groups

Type of Treatment	Description of Treatment	Factors Specific to Treatment Modality		Total Hours of Treatment per Patient*	
		Short-Term	Long-Term	Short-Term	Long-Term
Individual psychotherapy	Included all patients. Most supportive-type done by primary therapists, mostly psychiatric residents, but occasionally by a psychiatric nurse or psychology student. Frequency: 1–3 times a week for 30–60 minutes; average = 2 hours a week.	Primary goal was crisis intervention and discharge planning—little time for other goals.	Goals much more varied, such as meaning of a symptom, rehabilitation in job setting, etc.	6.0	24.0
Family therapy	Included all patients who had significant others (about half the patients). Done by cotherapists, one of whom was usually the primary therapist. Frequency: 1–2 times a week; usually twice with short-term patients. A weekly 90-minute multiple family therapy session was also conducted with about 2/3 of the long-term patients; average = 1 hour a week for long-term patients only.	Focus was on discharge planning.	Goals included both change in family patterns and discharge planning.	5.0	21.0
Group therapy	Included all patients. Led by trainees in several disciplines. Frequency: 2 times a week for 90 minutes. Two groups of 8–13 patients. A transactional analysis group met once a week with an equal mix of short- and long-term patients.	No difference		4.5	18.0
Milieu therapy	Included a role play group attended by all patients, a treatment planning group consisting of all staff and patients on a particular team focusing on treatment planning and problems, and a discharge planning group focusing on discharge (all weekly); also, various activity therapy groups such as crafts, shopping, cooking, and swimming that met throughout the week. Short-term patients spent as much time with nursing staff as long-term patients during first 4 weeks.		Received more thorough discharge planning, most of which occurred in the last 2/3 of hospitalization.	60.0	240.0

*Figured on the basis of the number of hours per week of treatment modality multiplied by 3 weeks for the short-term group and 12 weeks for the long-term group.

and all were significant ($p<.01$). The reliability of the average of the scores is, of course, somewhat better than that of the single ratings.

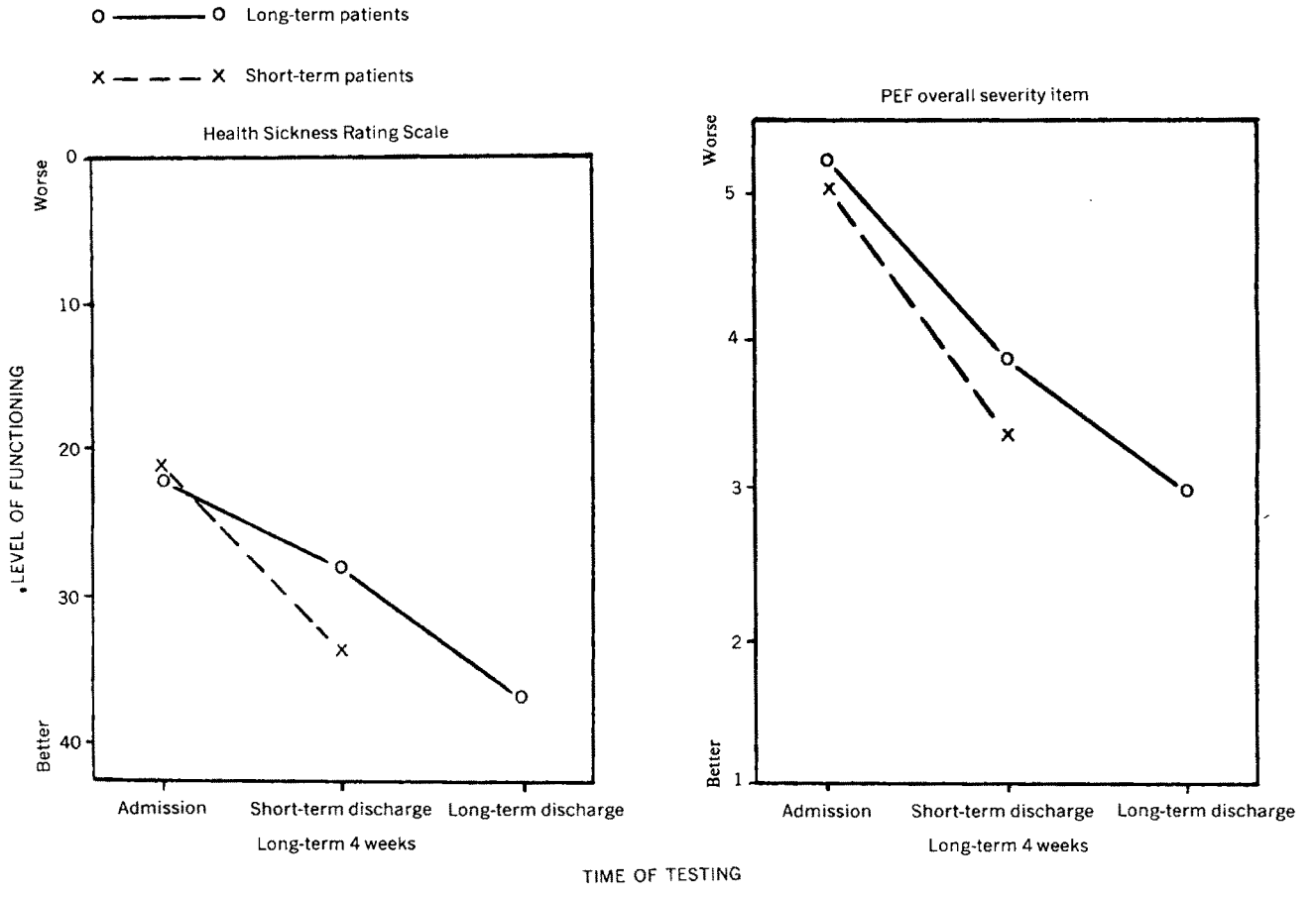
The Psychiatric Evaluation Form (PEF) (5) contains 20 mental status items and 5 role impairment items. There are also 5 PEF summary scales that are combinations of individual items—disorganization, subjective distress, antisocial, withdrawal, and grandiosity-externalization. The scale is accompanied by a semi-structured interview guide. Five members of the nursing staff were trained to use this interview and reliably rate these items. As in the case of HSRS, these raters knew the treatment assignments.

Two independent PEF ratings were done on a sample of 36 interviews in order to estimate reliability. Correlations for the 19 symptom scales ranged from .75 to .97 and, because "don't know" was a possible answer, sample sizes ranged from 26 to 36. The correlation for overall severity was .84. The five summary scales on the PEF were also correlated for these 36 interviews; correlations ranged from .86 to .95.

Data Analysis

The principal method used to analyze the data was a three-way analysis of covariance, Treatment Assignment (short- or long-term) × Sex × Paranoid Status (paranoid or nonparanoid). The dependent variables were discharge scores and (in a second set of analyses) comparison of short-term patients at discharge to the long-term patients at four weeks after admission; the admission score on the same variable was the covariate. Scatter plots of the relationship between admission scores and each dependent

FIGURE 2
Mean Scores for Short-Term and Long-Term Patients on the Health-Sickness Rating Scale and the Psychiatric Evaluation Form Overall Severity Item



variable (four-week and discharge scores) for the long- and short-term groups separately were examined and seemed to be sufficiently linear and homogeneous to justify the use of analysis of covariance. An exception was the PEF antisocial scale—many of the patients did not show this symptom, so an additional analysis was performed for this scale for only those patients whose initial scores indicated some degree of the symptom.

RESULTS

Global Outcome

Global outcome on the HSRS and the PEF overall severity item are shown in figure 2. At 4 weeks, the short-term group was rated as functioning significantly better than the long-term group on the HSRS ($p<.01$). (All tests were two-tailed unless otherwise indicated.) The short-term group was also rated as functioning better than the long-term group at 4 weeks on the overall severity item of the PEF, but the difference did not reach significance ($p<.10$). At discharge, the long-term group was functioning significantly better than the short-term group at its earlier discharge time on both the HSRS ($p<.01$) and on overall severity ($p<.05$). The main effects and interactions of sex and paranoid status were not statistically significant.

We next looked at the tails of the sample to find out which patients were most improved and which were least improved or had gotten worse (table 3). At 4 weeks, 22 of the 30 patients who improved most on the HSRS were short-term, while 15 of the 24 patients who improved least were long-term ($p<.02$). At respective times of discharge, 24 of the 28 patients who improved most were long-term, while 21 of the 30 who improved least were short-term ($p<.001$). Results on the overall severity item of the PEF showed a similar trend, but the difference did not reach statistical significance.

Symptoms

Figure 3 presents the means on the PEF summary scales for the long- and short-term groups at admission, 4 weeks, and discharge. The tendency was for the groups to be about the same symptomatically at admission. At 4 weeks, both groups had improved markedly on all summary scales except the antisocial scale, a finding that is not surprising, given the low initial symptoms on this scale. The short-term group showed significantly less

symptomatology at four weeks than the long-term group ($p<.05$) on two of the five summary scales, subjective distress and withdrawal.

At the time of discharge there were no significant differences between the two groups on these five summary scales, but there was a trend ($p<.10$) for long-term patients to be rated lower on disorganization and grandiosity-externalization. As with the HSRS, there were no significant main effects of sex or paranoid status and no significant interactions of these variables with treatment assignment.

We performed t tests between the groups on each of the 19 PEF items using the difference between the four-week and admission ratings and the difference between the discharge and admission ratings. At 4 weeks the short-term patients had improved significantly more on hallucinations ($p<.05$), social isolation ($p<.05$), and depression ($p<.01$). At the time of discharge the long-term group had improved significantly more than the short-term group on agitation-excitement ($p<.05$), belligerence-negativism ($p<.05$), and inappropriate affect ($p<.05$).

Selected Sample

An additional question is whether there would be a difference in our conclusions if we analyzed data for only those patients who met our original criteria for the study rather than the total sample. Some patients had been hospitalized elsewhere for more than 7 days in the 2 months preceding admission; some stayed for less than the required number of days for short- or long-term hospitalization, leaving against medical advice. A few patients were hospitalized longer because they were a danger to themselves or others. We omitted all of these patients from the sample and repeated the same analyses of covariance with this selected sample ($N=97$, 53 short-term and 44 long-term). This analysis did not alter the conclusions derived from the larger sample.

TABLE 3

*Distribution of Those Patients Most and Least Improved According to Global Outcome Measures**

Measure	Improved Most		Improved Least	
	Short-Term	Long-Term	Short-Term	Long-Term
Health-Sickness Rating Scale				
At 4 weeks**	22	8	9	15
At discharge***	4	24	21	9
Psychiatric Evaluation Form overall severity item				
At 4 weeks	7	2	10	14
At discharge	7	12	10	7

*Approximately 20 percent of the total sample ($N=141$) fell into each of the categories of improvement for the HSRS, and on the PEF, "most improved" was a change score of −4 or −5 and "least improved" was a change score of 0, +1, or +2.

**$p<.02$, chi-square test, corrected for continuity.

***$p<.001$, chi-square test, corrected for continuity.

DISCUSSION

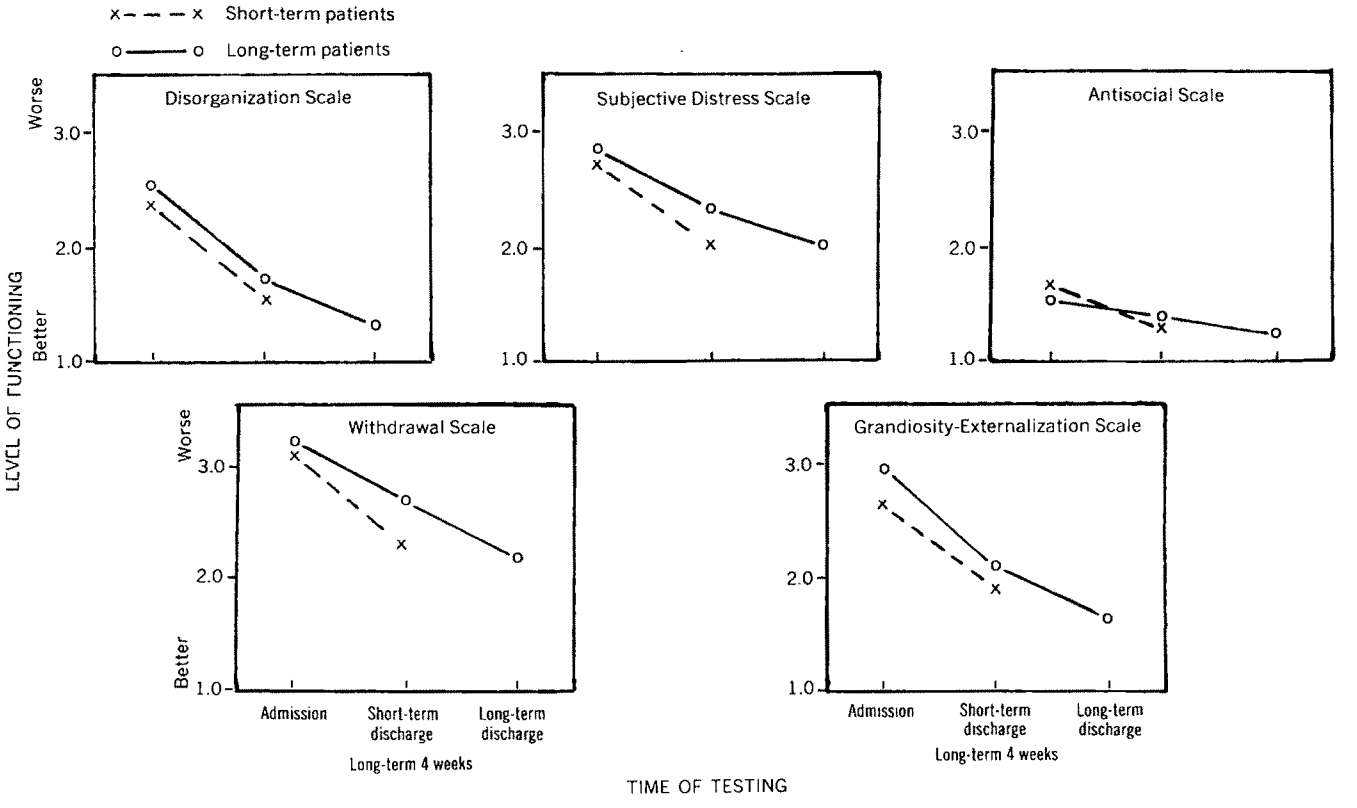
In terms of global functioning, the short-term patients in our sample of schizophrenic inpatients (for whom there was greater emphasis on crisis resolution and discharge planning) pulled together and functioned better at 4 weeks than did the long-term patients (for whom treatment was expected to extend for three or four months). This is not a pharmacological effect, since drug dosage levels were similar in the two groups. The early improvement of the short-term group may have been produced by the patients' awareness that they would soon need to function outside the hospital. The qualitative differences in the interpersonal aspects of the treatment may also have been a factor. These seem to us to be the most plausible sources of the effect. It is also possible that the short-term patients had mobilized themselves just prior to their discharge, which is when they were assessed, while long-term patients were under no such pressure at the time of their 4-week assessment. Finally (and, we feel, least likely), the impending discharge of the short-term subjects may have introduced a bias that led raters to rate these subjects as functioning better than they actually were. Long-term patients did continue to improve, and at discharge at 90 to 120 days functioned better than did short-term patients at 28 days.

The results suggest that some specific symptoms clear faster with our short-term approach than with our long-term treatment. There may be little additional advantage to be gained in symptom reduction from keeping patients for a longer hospital stay. These results are consistent with those of Caffey and associates (2): in both studies, the short-term patients had milder symptoms than the long-term patients at 4 weeks. In the Caffey and associates study, short-term patients had less symptomatology on all variables except one, with significant differences on the retardation and motor disturbances items. In our study, the significant differences were on subjective distress and withdrawal. In both studies, the long-term patients had less symptomatology at discharge than did the short-term patients. In the Caffey and associates study, the long-term group had significantly lower scores on the paranoid projection, perceptual distortion, grandiose expansiveness, and conceptual disorganization items at discharge. In our study, long-term patients tended to show less disorganization and grandiosity-externalization, but the other symptom clusters did not show greater improvement.

The data reported here do not permit comparison of the level of functioning of long-term patients at discharge with short-term patients at the same time, i.e., about 3 months after their admission. We do not know whether the continued improvement shown by the long-term patients is greater than any postdischarge improvement that may have been shown by the short-term group in the two months after their earlier discharge.

The short-term group had less education, lower socioeconomic status, and poorer premorbid adjustment. One might predict poorer outcome for the short-term group

FIGURE 3
*Mean Scores for Short-Term and Long-Term Patients on Psychiatric Evaluation Form Summary Scales**



*Higher scores indicate more symptomatology.

because of these characteristics, but since the short-term group actually improved more quickly, it seems unlikely that the results were due to the initial differences between the two groups.

Given the differences in effectiveness we have reported at the end of the inpatient phase, one must ask whether the longer stay is worth the extra cost. Our data in this phase of the study can only begin to answer this question, but if one used global functioning or symptoms at 4 weeks as a criterion, longer hospitalization for schizophrenics would not be worth it.

However, the preliminary results of our one-year follow-up suggest that these cost differences may be equalized in the long run by differing patterns of utilization of inpatient and outpatient services by the two experimental groups. Therefore, before discarding long-term treatment, it is necessary to see the complete follow-up data for these two groups of patients 1 and 2 years after admission. This follow-up is now in progress.

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Current and Emerging Models of Residential Psychiatric Treatment, with Special Reference to the California Situation

BY ROLAND M. ATKINSON, M.D.

The author reviews the steps that have led to the progressive deemphasis of psychiatric hospitalization in California and surveys the empirical basis for rejecting the usefulness of hospitalization. He discusses the four alternative residential models that have emerged in California as substitutes for state mental hospitals—general hospital psychiatric units, board and care homes, private psychiatric facilities available through vendor contracts, and convalescent hospitals. The author also touches briefly upon some important problems, including the possible fate of public general hospital psychiatric units, community mental health services, and the commitment law in California.

HOSPITALIZATION WAS UNTIL recently the principal intervention used nationally by public psychiatry (1). California's status as a bellwether for possible national change in public psychiatry began in 1956 when Dr. Daniel Blain, then Director of the California Department of Mental Hygiene, announced that the state intended eventually to close all of its mental hospitals in favor of community-based programs. Following this announcement, in 1957 the California legislature enacted the Short-Doyle program, which permitted the development of county-sponsored but largely state-funded mental health service delivery systems.

Because of this program's success in reducing the use of state hospitals while expanding outpatient programs in most urban communities, the legislature in 1969 mandated the development of similar programs for all counties with populations of 100,000 or more, and also passed the Lanterman-Petris-Short (LPS) Act, a reformed commitment law that placed great constraints on the involuntary confinement of patients. In 1971 the legislature further mandated that hospital services henceforth would receive the lowest priority for funding of new and expanded programs. In early 1973 the Division of Mental Hygiene announced a five-year plan to eliminate all but two of the remaining state hospitals for the mentally ill (2), although controversy over this plan has resulted in its being shelved, at least temporarily (3, 4).

While a major effect of these steps over the past 19 years has been a significant reduction in the use of hospitalization compared with other forms of intervention, there has also developed a climate of antipathy toward the use of psychiatric hospitalization in the public sector, along with great enthusiasm for alternative interventions (5). In turn, the fervent antihospitalization bias of some influential psychiatrists in the state has affected both legislation and policies in public psychiatry (6). To place these matters in perspective, it may be useful for me to review briefly selected aspects of the empirical research on hospital treatment.

RESEARCH ON HOSPITALIZATION

While the utility of psychiatric hospitalization has been seriously challenged in recent years, debate has often depended far more upon rhetoric than upon properly generalizable empirical data. There are several important categories of variables that limit the generalizability of data, including the following: 1) demographic differences in the communities that the hospitals serve; 2) differences in the communities with respect to the development of alternative social and psychiatric resources; 3) differences in the hospitals themselves with respect to administrative policies, treatment philosophies, and the size, composition, and caliber of professional staff; and 4) differences in a number of patient characteristics, including prehospitalization social and behavioral adjustment, duration of illness, prior treatment, diagnosis, specific maladaptive behaviors, current family and other social supports, and legal status (voluntary or involuntary commitment) at the time of admission. It is obvious from these considerations alone that any statement to the effect that "hospitalization is good" or that "hospitalization is bad" must be viewed with sharp suspicion.

The interpretation of research on the efficacy of hospitalization also requires that one appreciate the nature and limitations of measures of outcome or efficacy. Commonly used outcome measures may be conveniently grouped into the following categories: 1) statistics concerning the consumption of hospital care, for example, length of stay in the hospital and rehospitalization rates; 2) measures of social conformity; and 3) measures of manifest symptoms and maladaptive behaviors using

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trained professional raters or self-rating instruments given to patients.

There are major problems with each of these categories. Data on the consumption of hospital services carry no inherent valence regarding desirable or undesirable consequences of treatment. Brief stays and low readmission rates may chiefly serve the interests of the funding agency, which is concerned with reducing expense to the state or local government (7). Measures of social conformity—for example, ratings of the discharged patient's adaptation to his family, community, or work—are based on the premise that the patient is "wrong" or unsuccessful if he fails to adapt to the presumed "rightful" expectations of his social environment, a premise that has been challenged by societal reaction theorists (8–10). Measures of manifest or self-reported psychopathology are vulnerable because of the inferential quality of many observations (11), which can lead to extreme errors in assessment (12). In addition, patients are capable of manipulating the clinican's impression of the degree of their illness according to their perceptions of the purposes of the assessment, a variable poorly controlled in most studies (13). The research literature itself will now be assessed according to selected categories of central interest.

Reasons for Hospitalization

Why do people enter the hospital? In their recent summary of the research literature on this question, Gove and associates (14, 15) concluded that the bulk of the evidence indicated that persons who are hospitalized are seriously disturbed, that hospitalization is initiated as a last resort after the situation in the community has become untenable, and that advocates of the social labeling theory of mental illness have probably overstated the importance of an automatic societal reaction mechanism in accounting for mental hospital admissions. A study conducted by Mendel and Rapport (16) at Los Angeles County General Hospital demonstrated the primary importance of the lack of alternative social placements in influencing decisions to hospitalize patients. My study (17) of 500 patients on the psychiatric emergency admitting unit at Orange County Medical Center showed that patients who were admitted to the hospital had fewer social supports and greater acute psychiatric impairment than those sent home.

Possible Undesirable Effects of Hospitalization

What is the effect of the length of hospital stay? Opponents of hospitalization have argued that inpatient treatment is antitherapeutic and debilitating. While two retrospective studies of psychotic patients have suggested that posthospital outcome is inversely related to length of stay (18, 19), the results of more carefully controlled prospective studies have not replicated this finding (20). In three of the four prospective studies reported (20–23), psychotic patients hospitalized for a longer period had a better outcome at subsequent follow-up than patients treated for a shorter time. However, the findings in two of these three studies may be biased by the fact that patients treated longer were also treated more intensively in the hospital (20). In the fourth prospective study (24) there was no difference in outcome for the short- versus long-term inpatient treatment. Thus, while overall data are inconsistent, the results of well-designed research support a tentative conclusion that thoughtfully prescribed hospital treatment can be an effective therapeutic intervention for at least some acutely psychotic patients.

The factor of disability is also related to the question of whether hospitalization is stigmatizing. Gove and Fain (14) also reviewed the literature on this question and contributed their own empirical study. While data do indicate that the public stereotype of the mentally ill is negative, data on the consequences of having been a patient in a mental hospital are much less definitive, although they tend to suggest a more benign picture. Gove and Fain could find only two studies in the literature that systematically reported on feelings of stigmatization among ex-patients and their relatives, and the results did not convincingly uphold the conclusion that harmful stigmatization occurred when patients returned to the community. In their own prospective study of discharged state hospital patients, Gove and Fain reported that most of the patients showed decided improvement in their relationships with cohabitants and modest improvement in instrumental performance in community activities; only a small minority appeared to see any stigma of hospitalization as having posed a problem to them.

While the final word is not yet in, and while it is likely that stigmatization must ultimately be understood in terms of the interaction among a patient, his family and community, and his specific hospital experience, it appears that Goffman (8), Sarbin (10), Mendel (cited in [5]), and others (14, 25) have overstated the case for stigmatization. On the other hand, there is a fair amount of support in the literature for the claim that social, economic, and other demographic factors, unfavorable earlier life experiences prior to hospitalization, and lack of sustained, long-term, active aftercare are all more decisive determinants of long-term disability than any specific treatment intervention, whether it be in the hospital or out of the hospital (26–30).

Efficacy of Alternatives to Hospitalization

Are alternatives to hospitalization effective? Controlled studies comparing the outcome of hospital treatment with the outcome of several nonhospital-based alternatives have perhaps had the greatest impact in calling the efficacy of hospitalization into question. In several carefully designed prospective studies, patients have been randomly assigned to full hospitalization versus partial hospitalization (31, 32), hospital treatment versus home treatment (33), hospital treatment versus outpatient family crisis intervention (34, 35), and hospital treatment versus immediate placement in autonomous living situations with outpatient therapy (36). All of these studies tend to demonstrate the superiority of the alternative intervention to hospitalization, with follow-up periods varying from a few months to three years. The superiority of the alternative intervention has been judged either by

equal outcome for the alternative treatment at greatly reduced cost or by an absolutely superior outcome compared with the results of hospital treatment or by both.

It must be emphasized, however, that highly selected patient groups have usually been chosen for these studies. The patients have usually been diagnosed as schizophrenic and have almost invariably been voluntary patients living with stable families, who in turn have been cooperative in accepting alternative treatment assignments. Usually, patients judged to have a significant risk of assaultive or suicidal behavior have been excluded from study, as have patients with other diagnoses or with concomitant acute medical problems, involuntary or committed patients, patients not living in stable families, and those whose families refuse to cooperate with treatment requiring that the patient reside at home part time or full time during the acute episode of disordered behavior. Thus a sizable proportion of patients who tend to be hospitalized have typically been excluded from study.

Moreover, this excluded group has many of the characteristics that tend to mitigate successful treatment in any setting, while criteria for inclusion suggest a bias toward patients for whom outcome is generally more favorable with any form of intervention. The alternative treatment program is usually staffed by a special team assembled for the study, and thus one may legitimately raise questions concerning uncontrolled differences in staff esprit and enthusiasm for the work, factors that have been demonstrated to increase the likelihood of successful outcome (37). Unfortunately, reports of comparative studies of hospitalization versus alternative interventions tend to minimize these important limitations of their findings. Thus it is not surprising that the more naïve popularizers of their findings, including government officials and politicians, have used these data to support the contention that hospitalization is ineffective and undesirable for all patients.

Conclusions

This very selective review of research on hospitalization allows the following tentative conclusions:

1. Two favorite claims of antihospital rhetoricians, that hospitalization is categorically stigmatizing and is also debilitating, are not generally upheld.
2. Studies comparing hospitalization with alternative interventions demonstrate the greater cost-effectiveness of the latter.
3. These studies focus on a circumscribed subset of the inpatient population that excludes large numbers of patients who are involuntary, who do not live in stable, cooperative families, who are medically ill, or who are destructive to themselves or others.
4. The question of the feasibility of nonresidential treatment for these excluded groups remains unanswered.

In addition, there are data showing that traditional state mental hospitals shelter a sizable group of patients who either resist active psychosocial rehabilitation efforts or are "treatment failures" but who, in any event, represent a hard-core group consuming open-ended residential care (13, 38, 39). It is the residential care of these latter groups to which California mental health planners have had to address themselves as the use of state hospitals has been purposely curtailed.

EMERGING MODELS OF RESIDENTIAL CARE

The following four alternatives to the state hospital have emerged in California, the latter two quite recently: expanded psychiatric inpatient units in county and city general hospitals, board and care homes, contracts to private residential service vendors, and convalescent hospitals. To facilitate discussion of these models, it will be useful for me to group the population at risk for residential care into these three major subsets: patients whose acute psychiatric disorders are caused by or coincidentally associated with major acute medical or surgical problems, rendering these patients medically nonambulatory (MED); medically ambulatory patients requiring primarily psychosocial and rehabilitative services (PSR); and medically ambulatory patients with chronic psychosocial disabilities not responsive to intensive intervention (DIS).

General Psychiatric Hospital Units

Richly staffed, geographically accessible, presumably nonstigmatizing psychiatric units in general hospitals were regarded until recently as a splendid alternative to the state mental hospital (40). Considerable expansion and enrichment of city and county general hospital psychiatric units occurred in the late 1950s and 1960s under the sponsorship of the Short-Doyle program. Since then, however, it has become obvious that these units have some important limitations. The following three problems are especially serious.

1. There has been a remarkable rise in the cost of general hospital psychiatric services, with the daily rates in California now about two to four times the daily rates in state mental hospitals.
2. The limitations of the general hospital ward setting hinder the development of optimal psychosocially oriented rehabilitation programs. These limitations include the constraints of the physical plant and hospital policies and staffing patterns arranged primarily for the care of nonambulatory medical and surgical patients.
3. These units still tend to be used as a last resort for many patients in the PSR and DIS groups, for whom general hospital services are often inappropriate and extraordinarily costly.

It is likely that the future justification of general hospital psychiatric units will have to depend more strictly upon their provision of highly medically oriented psychiatric evaluation and treatment, primarily to the relatively small subset of MED patients.

Board and Care Homes

Often rationalized as a step toward promoting patients' ties with the general community, these facilities for both PSR and DIS patient groups have appealed to state planners not only because they are less costly than

either general hospital units or state hospitals, but also because the state can transfer a large portion of the financial burden for such care to the federal government, which will subsidize ex-patients living in these facilities on the basis of total disability grants. Recent exposés of conditions in board and care homes in both the professional literature and news media suggest that the living environment in them is often inferior to that in hospitals (5, 41). Supervision of the homes and their operators is still a haphazard affair. The board and care home system has not been adequately linked to either the Short-Doyle program or comprehensive medical services, and the eligibility criteria for total disability grants limit access of ex-patients to these facilities. Thus these homes often provide an inadequate rehabilitative environment for PSR patients, and a large proportion of DIS patients—for example, those diagnosed as suffering from alcoholism or severe personality disorder—are not eligible for subsidy to live in them.

Private Vendors

There are several corporations that own and manage multiple private psychiatric facilities. In Orange County, the number of private psychiatric beds tripled in the last few years. This expansion was supported largely by the availability of Medicare and Medicaid (the Medi-Cal program) funding, which today subsidizes the care of many patients who formerly would have been sent to state or county mental hospital facilities. According to a recent legislative mandate, these private vendors are now eligible to enter into competitive bidding to provide contract services in lieu of direct Short-Doyle facilities if they can demonstrate superior cost-effectiveness. Although only a few publicly funded contracts have been awarded to these private vendors, there are indications that this form of service for full and partial hospitalization, for both MED and PSR patient subsets, may increase in importance over the next few years.

Convalescent Hospitals

Most recently, the state mental health planners have been working with the Orange County Mental Health Department on pilot projects to convert and upgrade underutilized private convalescent hospitals for residential treatment of the PSR patient group.[1] The convalescent hospital vendor delivers basic hospital services, including core nursing staff, while the Short-Doyle program supplements the hospital staff with a cadre of mental health professionals to supervise the treatment program. If this psychiatrically upgraded convalescent model succeeds, it could largely replace county hospital psychiatric units and state hospitals in the treatment of the PSR patient subset. Some of the problems that may be encountered in the use of this new model will be discussed later in this article.

[1]These hospitals are called therapeutic residential centers, or TRCs.

UNRESOLVED PROBLEMS

Responsibility for MED patients. There is evidence that at least some state planners, moved by both fiscal and ideological arguments, would like to remove the care of the MED patient subset from the purview of the Short-Doyle program, reshaping the latter according to a strictly psychosocial rehabilitation model. Conceptually, this point of view implies that patients whose behavior disorders have a medical etiology or are at least associated with acute medical problems should be considered categorically different from patients whose behavior disorders have no obvious medical correlates. The potential destructiveness of this suggestion, with respect to both scientific issues and practical considerations of continuity of patient care, should be obvious to all medically oriented psychiatrists.

Management of PSR patients. The plan outlined earlier assumes that PSR patients will not be sent to traditional hospitals, but rather that community mental health services will provide intervention for patients with serious, acute behavioral disturbances that are not medically related. Several factors cast doubt upon the attainability of this goal. Many community mental health professionals still tend to view the general hospital psychiatric unit and the state hospital as a last resort for the most difficult-to-manage patients, and they have a concomitant reluctance to assume ultimate responsibility for these patients. Available convalescent hospital facilities tend to lack the architectural features required for safe and humane detention of involuntary patients who may be seriously dangerous to themselves or others. Also, funding levels proposed by the state for convalescent residential facilities are quite low, somewhat lower even than current per-capita funding for state hospital care. Thus it is questionable whether a staff-to-patient ratio can be achieved that would allow for adequate social control of the more seriously disturbed PSR patients.

The burden of the DIS patients. If the accelerated plan for closing state hospitals is adhered to, and unless the serious shortcomings of board and care homes are resolved, decentralized, extrahospital residential centers sponsored by the Short-Doyle program may be faced with another increasingly difficult burden, that of responsibility for the supervision of growing numbers of DIS patients. In Orange County it has already been proposed that low-cost, minimally supervised residential facilities (e.g., halfway houses, open-ended partial hospital programs, and "residential lodges") supplant board and care homes for many DIS patients, especially those who have resided for long periods in state hospitals, which may be closed. If community mental health services are sufficiently affected by the quasi-custodial burden of open-ended billeting of DIS patients, the active treatment mission for which these services are currently organized may be seriously compromised.

Status of the LPS commitment law. Apprehension by both the public and by legislators about the consequences of curtailing traditional hospital-based residential treatment models has resulted not only in shelving the state's

plan to close state hospitals nearly completely but also in controversy about the adequacy of the LPS commitment law (4, 41). Unfortunately, empirical research on the question of increased community hazards in relation to curtailed commitment and extrahospital treatment is inadequate to resolve the issue. A paucity of studies may be cited on each side of the coin: some data suggest that there is no demonstrable increase in hazard to the community from ex-mental patients (42, 43), while other studies suggest that there is some increased incidence of arrest, if not of crime, among discharged mental patients (36, 44, 45).

While the link between prior psychiatric treatment and major crimes of violence has been played up by the news media recently in a few celebrated cases (41), by far the more important problem appears to be the increasing burden on law enforcement agencies of apprehending and jailing psychiatric patients who are lost and wandering around the neighborhood or, less frequently, exhibiting bizarre behavior (6, 41). The restrictive provisions of the LPS law are frequently blamed for this phenomenon (4, 6, 41). Whether irrational or not, political pressure could result in modification of the commitment law, for example, in loosening the criteria for commitment and extension of involuntary confinement, at the expense of further abridgments to patients' civil liberties.

SUMMARY AND CONCLUSIONS

Even in California, some forms of public residential psychiatric treatment appear to be here to stay. This is not surprising considering the unresolved questions concerning the feasibility of abolishing all residential treatment, whether viewed from the vantage point of research, clinical experience, or public concern. General hospital psychiatric units will increasingly be forced to restrict their activity to the care of the psychiatric patient with medical complications, while less expensive community-based models are being sought for residential programs that are more properly oriented to psychosocial intervention and rehabilitation. The care of the chronically socially disabled patient who requires or demands some form of residential placement continues to be a problem for which adequate answers have not been found.

Several important spectres haunt the mental health system and the public. One is the possibility that community services may be rendered ineffectual by virtue of their increasing responsibility for the care of untreatable patients who are chronically socially disabled. Another possibility is a backlash against the community mental health service system and its ideology, related to unfounded public fears about mental patients in the community and perhaps also to the fact that the community-oriented philosophy in psychiatry is grounded to some extent in optimism and hope and not entirely in proven methods, except for small research and demonstration projects, the broad application of which may be fiscally impossible (46). One may hope that a middle-of-the-road approach will ensue in which the cautious, gradual development of residential alternatives to the traditional hospital models will displace extremist measures and debates. On the other hand, it is entirely possible that the current wave of public and legislative sentiment may result in retrogressive changes in both the public mental health service delivery system and in the commitment law, in keeping with the national trend toward increasing conservatism on most social issues.

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Intellectual and Neuropsychological Functions in Young Men with Heavy and Long-Term Patterns of Drug Abuse

BY PETER BRUHN, CAND. PSYCH., AND NELLY MAAGE, CAND. PSYCH.

The authors attempted to determine the long-term effects of heavy drug abuse in 87 male prisoners. The sample was divided into the following groups: 1) nondrug users; 2) users of cannabis and hallucinogens; 3) users of cannabis, hallucinogens, and amphetamines; and 4) users of cannabis, hallucinogens, amphetamines, and opiates. Intellectual and neuropsychological tests sensitive to brain dysfunction revealed no intergroup differences. This finding casts some doubt on other reports suggesting that long-term drug abuse results in neuropsychological disorders. However, the authors caution that one should not conclude that no organic changes occurred in their sample.

THE STEADILY INCREASING use and abuse of mind-altering substances, in particular hallucinogens, amphetamines, barbiturates, opiates, and psychotropic drugs, has inevitably resulted in a growing concern about the social, psychological, and biological consequences for the user. The research literature on the subject has focused mainly on the following two questions: What are the acute effects of drug abuse on the organism? and, What are the possible (incapacitating) long-term effects of chronic use of the previously mentioned drugs?

REVIEW OF THE LITERATURE

While there is a vast research literature on the first question (e.g., 1–4), only a few valid investigations of the second question have been published (5–7). This seems to be particularly true with respect to permanent deficiencies of a neurological or neuropsychological nature. The literature on this latter issue is contradictory, due in part to a number of methodological problems previously enumerated elsewhere (e.g., 1). Von Zerssen and associates (5), who used echoencephalography, reported enlarged third ventricles of the brain in drug abusers. This is in accordance with the findings of Campbell and associates (6), who through the use of pneumoencephalography found cerebral atrophy in young patients who had a history of consistent cannabis smoking over a period of 3 to 11 years.

Kolansky and Moore (2) found neurologic signs and symptoms such as "slurred speech, staggering gait, hand tremors, thought disorders, and disturbances in depth perception" in a few patients who had smoked marijuana four or five times weekly for many months. In a study that used tests sensitive to cerebral impairment, subjects who used hallucinogens showed significant impairment suggestive of "some degree of cerebral deficit" (7).

Further evidence of the detrimental effects of hallucinogenic drugs on cerebral function may be indicated by the "amotivational syndrome" described by McGlothlin and West (8). This syndrome, which has been observed in chronic, heavy marijuana users, is characterized by such symptoms as weakening of normal aggressivity and ambition, increased fatigue, and a tendency to "drop out." Thus the syndrome in many respects resembles the asthenic syndrome known in clinical neurology as one possible consequence of cerebral injury.

However, several other studies cast some doubt on these reports of adverse cerebral effects from long-term drug abuse. Kupfer and associates (9) related impaired motivation to factors other than frequent marijuana use, and Grant and associates (10) found no evidence of neuropsychologic impairment in students who had smoked marijuana moderately and regularly for at least three years.

In addition, two U.S. government reports (3, 4) were equivocal about the possibility of harmful effects from long-term use of marijuana. The latter report stated that "knowledge of the effects of very heavy, very long-term use of marijuana by man is still incomplete" (p. 62).

There is even less information concerning the effects of the more potent psychoactive drugs relevant to this study. LSD has often been reported to induce recurring effects in the form of flashbacks and visual disturbances (11, 12) that outlast the effects of the individual dose. This seems to indicate that it has a permanent or at least long-lasting influence on the central nervous system. However, in McGlothlin and associates' study (1) of subjects who had repeatedly ingested LSD, they reported only vague evidence of "moderate impairment of abstract abilities . . . suggestive of minimal brain damage."

Louria (13) has cautiously suggested that the abuse of

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stimulants may result in organic brain damage. Opiates, especially heroin, have been reported in several cases to cause damage to the central nervous system, probably due to the users' hypersensitivity to the drug (14). Morphine base,[1] one of the most popular opiates in Denmark in the last few years, has been suspected of causing similar central nervous system impairment in patients seen in our neurological clinics, but little is yet known about the long-term effects of this substance due to its rather recent appearance on the market. The determination of central nervous system impairment from these drugs is complicated by the fact that many drugs bought on the black market are dissolved in or mixed with other substances that might contribute to or cause neurological dysfunction.

Based on these observations, it must be concluded that the possible detrimental effects of long-term drug abuse on the central nervous system are not sufficiently elucidated. The purpose of our investigation was to answer the following questions:

1. Does heavy, long-term drug abuse result in neuropsychological impairment, either in the form of dementia or in more selective cognitive deterioration?
2. Are certain drugs (hallucinogens, stimulants, and opiates) especially detrimental to the cognitive abilities of the user?

METHOD

Subjects

Eighty-seven male subjects were randomly selected from a larger sample of criminals imprisoned in Vestre Faengsel (the state prison), Copenhagen, for various violations of the penal code. They comprised the total sample studied. Their mean age was 23.1 years (range, 17 to 32 years); the mean level of general education was 8.2 years (range, 6 to 12 years); and the level of higher education averaged 1 year (range, 0 to 8 years).

The criteria for exclusion from the study were as follows:

1. Acute or chronic physical disease (e.g., fever, hepatitis, drug withdrawal symptoms).
2. Acute or chronic gross psychopathology (e.g., psychosis, schizophrenia, manic-depressive disease) or oligophrenia.
3. Evidence of damage to the central nervous system from causes other than drugs (e.g., previous head trauma and neurological disease), based on information from an interview.
4. Sensory or motor deficits influencing the subject's ability to take the neuropsychological test battery.

All subjects were briefly informed about the tests they were going to take. In addition, they were told that the study psychologist was not working for the prison and that neither personal information nor test data would be given to the police, prison administration, or other authorities. Only voluntary subjects were accepted; almost all selected subjects cooperated, since the investigation represented a welcome interruption of the boredom experienced in the cell.

One of us (N.M.) obtained the drug history of each subject during a careful interview. Concerning drug intake, it is extremely difficult in an extralaboratory setting to obtain exact information on the chemical composition and amount of intoxicating substances taken over the years. The drug user usually has little knowledge of exactly what he is buying. His memory, as well as his personal motives, further distorts the information elicited. To circumvent the latter problem, we spent a great deal of time developing a positive relationship with the subjects. This, together with the fact that they knew their drug histories would be kept confidential, leads us to believe that we got a fairly realistic and honest description of each subject's drug history.

We attempted to characterize the pattern of drug abuse in our sample, based on frequency, by using the classification suggested by the National Commission on Marihuana and Drug Abuse (4, p. 34). It is as follows: experimenters: have used the drug for a few trials but never regularly; intermittent users: use the drug two to three times a month to once a week; moderate users: several times a week to once daily; and heavy users: more than once daily.

Based on this information the subjects were divided into four groups representing different patterns and degrees of drug intake, as follows: group 1: nondrug users (N=23);[2] group 2: cannabis plus hallucinogens (N=22); group 3: cannabis, hallucinogens, and amphetamines (N=20); and group 4: cannabis, hallucinogens, amphetamines, and opiates (N=22).

Although the selection of the four groups may seem somewhat arbitrary, it is obvious that they represent increasing degrees of drug abuse in regard to both the amount and types of drugs ingested.

We were careful to match the four groups with respect to age and educational level, as well as to the number of years spent in public or private institutions.

Table 1 summarizes the characteristics of the 87 subjects in regard to the kind and amount of drugs used. It can be seen that abuse of barbiturates, cocaine, heroin, and psychotropic drugs (usually sedatives) was fairly common in group 4.

Procedure

After a short conversation in the cell, where the psychologist described the study to the subject and elicited his cooperation, the two settled in a quiet office, where detailed information on the subject's social background and drug use was obtained in an informal and relaxed atmosphere. This interview usually lasted about a half-hour to an hour.

Next, the subject was informed about the tests he was

[1]Morphine base refers to the basic, unpurified substance from which other and more pure opiates, e.g., heroin, are derived.

[2]Although some members of this group had used cannabis and other drugs experimentally and three had used cannabis intermittently, for the purposes of this study they are considered nondrug users.

TABLE 1
Patterns of Drug Use Among 87 Subjects

Types of Use	Cannabis	LSD	Mescaline	Amphetamines	Opiates	Morphine Base	Heroin	Cocaine	Psychotropic Drugs	Barbiturates
Group 1 (N=23)										
Experimental	12	2	0	6	2	3	0	0	1	1
Intermittent	3	0	0	0	0	0	0	0	2	0
Moderate	0	0	0	0	0	0	0	0	0	0
Heavy	0	0	0	0	0	0	0	0	0	0
Group 2 (N=22)*										
Experimental	0	8	1	16	10	6	1	2	2	1
Intermittent	3	6	0	2	0	0	0	0	2	0
Moderate	12	2	0	0	0	0	0	0	0	0
Heavy	7	0	0	0	0	0	0	0	0	0
Group 3 (N=20)**										
Experimental	3	3	0	0	9	6	0	1	2	0
Intermittent	1	8	0	0	0	1	0	0	7	0
Moderate	3	6	0	7	0	0	0	0	1	0
Heavy	13	0	0	13	0	0	0	0	0	0
Group 4 (N=22)***										
Experimental	1	2	3	1	1	0	6	3	3	1
Intermittent	0	6	0	2	2	0	0	2	0	3
Moderate	0	7	0	3	2	0	0	2	3	1
Heavy	21	2	0	16	17	22	0	1	13	12

*This group had used cannabis from two to eight years.
**This group had used cannabis from two to seven years and amphetamines from one to seven years.
***This group had used cannabis from three to six years, amphetamines from one to six years, and synthetic opiates from one to five years.

going to take, and the psychologist urged him to perform at his very best. The testing usually lasted for two to three sessions. It always started with the Wechsler Adult Intelligence Scale (15), after which the neuropsychological test battery was administered.

The following tests were used:

The Wechsler Adult Intelligence Scale (WAIS) (15). This scale, which is composed of 11 subtests covering a variety of cognitive areas, was used to calculate the subjects' IQs.

The Halstead Category Test. In several studies this test has been found to be an extremely sensitive indicator of brain dysfunction (16, 17).

Learning and memory tests. A verbal learning test (15 paired associates) and a visuospatial learning test (reproduction of 4 complex geometrical designs) were administered. After an interval of one hour, during which time the subject was taking several other tests, he was told to reproduce the verbal response items as well as the geometrical designs.

The Seashore Rhythm Test. This auditory test evaluates the subject's auditory perceptual accuracy and short-term memory, as well as his sustained attention. It, too, has proven very sensitive to generalized central nervous system dysfunction (16).

Hidden Patterns Test (18). This test evaluates the subject's ability to analyze complex designs and detect a certain pattern.

Continuous reaction time test. The reaction time equipment consisted of a light source, which emitted a red light, placed 2½ feet in front of the subject. In response to the stimulus the subject depressed a microswitch as fast as possible, thus switching off the light. Motor response latencies (up to 1/100 of a second) to these visual stimuli were measured on an electronic clock. After 15 practice trials, 100 continuous reaction times were recorded. The stimuli were presented semirandomly and without warning at a rate of 15 per minute, thus putting stress on the subject's ability to concentrate on a monotonous task for a relatively long period (about 10 minutes). Mean response latencies and intrasubject variability have been found to be an extremely sensitive indicator of brain damage by several investigators (e.g., 19).

RESULTS

Intelligence. There were no significant differences among any of the groups on the mean raw subtest scores of the WAIS or on the mean verbal, performance, and full-scale IQs. There was not even a tendency toward lower IQs in the more severely drug abusing groups. The mean verbal IQs for groups 1–4 were 112.3, 108.6, 111.0, and 114.6; mean performance IQs, 107.2, 106.2, 109.2, and 111.0; and mean full-scale IQs, 110.9, 107.9, 110.9, and 113.9, respectively. Although the IQs generally ranged from about 110 to 115, one should not consider this sample to be of above normal intelligence. The WAIS is not standardized in Denmark, and an IQ of 110 to 115 is known to represent average intelligence.

Neuropsychological functioning. The mean group scores on the neuropsychological test battery are presented in table 2. The Kruskal-Wallis one-way analy-

TABLE 2
Mean Group Scores on the Neuropsychological Test Battery

Item	Group 1 (N=23)	2 (N=22)	3 (N=20)	4 (N=22)	Chi-Square Value*
Category Test**	44.1	42.6	46.1	41.0	1.4
Verbal learning test**	14.9	14.7	15.6	12.1	2.1
Verbal memory test**	4.1	4.1	4.1	3.1	3.0
Nonverbal learning test**	2.9	2.0	1.4	2.1	6.6
Nonverbal memory test**	3.0	3.6	2.6	2.0	3.8
Seashore Rhythm Test***	24.2	25.0	23.9	24.3	1.3
Hidden Patterns Test***	70.0	67.9	71.8	70.4	0.9
Reaction times (milliseconds)	266.0	254.0	258.0	265.0	2.8
Reaction time lapses	4.0	2.6	3.2	4.0	2.0

*None of the chi-square values were significant.
**Errors.
***Correct answers.

sis of variance by ranks (20) was used to determine whether differences among the four groups were significant.

There were no significant differences among the groups. The error scores on the Halstead Category Test did not indicate any particular deficit in concept formation or utilization on an abstract level. Learning capacity and memory, whether of a verbal-associative or visuospatial nature, were well preserved in groups 2–4. We found no impairment in the subjects' auditory perceptual efficiency (Seashore Rhythm Test) and visual perceptual efficiency (Hidden Patterns Test).

The continuous reaction time test, which is sensitive to changes in vigilance and attention, did not reveal any retardation. Mean reaction times were about the same in all groups, and the occurrence of lapses or prolonged latencies (arbitrarily defined as reaction times equal to or more than 400 milliseconds) as an index of inattention did not indicate any particular deficiencies in the drug-using groups.

DISCUSSION

The drug-using groups had comparable levels of performance. We found no differences in any variable—neither between the controls and the drug sample nor among the three drug-using groups. Thus the answers to our questions are that drug abuse does not lead to a general or selective intellectual impairment and that certain types of mind-altering substances (hallucinogens, stimulants, and opiates) do not impair the intellectual functioning of the user.

These findings were surprising; they are not consistent with those of several other investigators who found differences between controls and drug users (1, 7). Specifically, we were unable to demonstrate any impairment in abstract thinking, as measured by the Halstead Category Test, in subjects with a history of heavy cannabis use. In addition, we did not find any disturbances in concentration, perception, learning capacity, or any of the other areas of cognition tested.

Our failure to demonstrate any kind of intellectual deficit in the drug-using groups may be due to methodological factors, which could have obscured possible differences. Consideration therefore should be given to the characteristics of the groups tested as well as to the validity of the tests used.

Most of the comparable investigations have used psychiatric patients or college students as experimental subjects. Our use of prisoners has the advantage of ensuring that the subjects were not using drugs during testing, a factor difficult to control in a more open environment. Acute drug intoxication of some subjects or too short a period of abstinence may have influenced the test results in other studies.

One may question whether our control group of non-drug-using prisoners was an adequate basis of comparison. In our opinion, the variable of exposure to the stress of being imprisoned and deprived of a normal social environment should be kept constant across groups. Even if the validity of the control group is questioned, however, the fact that there were no differences between the groups using soft and those using hard drugs further favors our conclusions.

The applicability of most of the tests as valid and sensitive measures of cerebral dysfunction has been clearly demonstrated elsewhere (15–17, 19). However, the psychometric method is inferential, and one should not conclude that no *organic* changes occurred, since this statement can only be based on direct neuroradiological or pathological findings.

Although we believe that there are grounds for cautious optimism concerning long-term adverse neuropsychological effects after years of heavy drug abuse, care should be taken not to minimize the risk of using mind-altering drugs. The lack of evidence of brain dysfunction does not exclude untoward neuropsychological effects that may become manifest at a later time or effects of a psychological and social nature.

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Prompt Publication Policy

The *Journal* would like to remind authors who are particularly interested in early publication (whether to establish priority of an idea, reveal innovative results of new research, or for other pressing reasons) of its prompt publication policy. Under this policy, short (maximum of six double-spaced pages) manuscripts will be considered for publication in the Brief Communications section of the first available issue. These manuscripts must still undergo expert scrutiny before being accepted, and two months must be allowed for the printing process. However, the time required for publication of these short articles can be lessened considerably.

Authors who would like to have their manuscripts considered under this policy should indicate this desire, as well as the reasons for it, when they submit their manuscripts.

Psychiatric Resident Suicide: An Analysis of Five Cases

BY ROBERT O. PASNAU, M.D., AND MAJ. ANDREW T. RUSSELL, MC, USA

The authors present case histories of five psychiatric residents in a large metropolitan area who committed suicide during an 11-year period. Although they found no single precipitant or predictor, they noted striking similarities in the cases, including a high incidence of psychopathology manifested in marital problems, absence of close personal relationships, previous psychotherapy, drug and/or alcohol abuse, etc. The authors suggest an interaction of personal, peer, and institutional factors as causal in all of these suicides and recommend such improvements in residency programs as providing individual faculty preceptors for each resident and facilitating psychotherapy for troubled residents.

THERE SEEMS TO BE a continuing controversy in the literature related to crude suicide rates among psychiatrists and other physicians (1–6). This controversy is probably of little use. If the suicide rate among psychiatric residents were very low, the death of only one individual would be of major concern to psychiatric educators and to the profession as a whole. If the rate were high, the figures alone would tell us little about the individuals involved, the effects of their deaths on others, or what could be done to prevent these tragedies.

We have been given access to the records of five psychiatric residents who committed suicide between 1960 and 1971 while enrolled in or shortly after leaving university-based psychiatric residency programs in a large metropolitan area of the United States. Our intent is to present these five "psychological autopsies" and to discuss the issues that emerge from them.

FIVE PSYCHIATRIC RESIDENT SUICIDES

Case 1. Dr. A was a 27-year-old single man whose academic record as an undergraduate was outstanding. He had graduated cum laude with a straight A average in only 3 years and had been accepted by a major medical school in the Southwest. His grades were not good in medical school, however, and they deteriorated as time progressed.

During the fall of his senior year, he was accepted for a clerkship in psychiatry in the program that later accepted him for residency. He impressed the faculty preceptor, who later recommended him for residency without any further interviews despite his poor overall academic achievement in medical school. His letters of recommendation were very favorable, indicating that his potential was much greater than would be assumed from his grades. After completing a rotating internship in a large general hospital, he began his residency. Almost 2 years had elapsed since he had had any physical contact with anyone in the program, and several faculty members who had known him were impressed by the change in his appearance and attitude. Almost immediately, his supervisors noted his lack of attentiveness and spontaneity, and his ward psychiatrist frequently noted his poor clinical judgment and irresponsibility. He did not attend conferences, was often late, and seemed uninterested in receiving counseling. After the first 6 months, he was placed on probation and advised to get psychiatric help. He refused and was dropped from the program after the first year. However, he was able to transfer to a smaller county hospital program for a second-year position. Shortly before his death from an overdose of barbiturates, he was under investigation for drug abuse by the state medical licensing board. He left no suicide note.

Case 2. Dr. B, a 28-year-old single man, graduated magna cum laude from a large eastern university where he was elected to Phi Beta Kappa and was captain of the baseball team. He continued to do well in medical school, where he received a scholarship. Recommendations from the dean and the psychiatric faculty were uniformly outstanding. During his senior year of medical school, he was interviewed by several faculty members of the program where he was later accepted, all of whom were very impressed with his sincerity and intelligence. Only one noted "certain emotional traumas in his own familial experience." This was not elaborated, nor was there any mention of previous mental illness. During his internship year, he asked that his residency be postponed for a year because he wanted to do some traveling. This request was approved without further interview. Two and one-half years after he first appeared for evaluation, he began his residency. His appearance had changed markedly (not, however, unlike that of many of his peers). He appeared preoccupied and distant. Evaluations from supervisors noted his "emotional distance" and his frustration with his patients' lack of progress. He was told to seek psychotherapy and he was giving this thought when, without apparent reason, he went into the desert and took an overdose of barbiturates. He left a suicide note in which he romanticized the experience of death. It was subsequently learned that he had been hospitalized for mental illness while in medical school and that he had used hallucinogenic drugs for some time.

Case 3. Dr. C was a 28-year-old unmarried man who graduated magna cum laude from a large western university where he was elected to Phi Beta Kappa. He did extremely well in medi-

Revised version of a paper read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

At the time this work was done, Dr. Pasnau was Director of Residency Education and Maj. Russell was a Fellow in Child Psychiatry at the University of California, Los Angeles, School of Medicine, Los Angeles, Calif. 90024, where Dr. Pasnau is now Associate Professor of Psychiatry and Chairman, Graduate Education Committee. Maj. Russell is with the Department of Psychiatry, Headquarters, U.S. General Leonard Wood Army Hospital, Fort Leonard Wood, Mo. The authors were members of the Task Force on Emotional Problems of Psychiatric Residents of the American Association of Directors of Psychiatric Residency Training when this work was done.

cal school, and his preceptor recommended his acceptance as a resident without further interview. Following an internship in a nearby Veterans Administration hospital, he began his residency. It was quite apparent on his first day that something was wrong. He appeared dazed and confused and he seemed unresponsive at times. He was seen in psychiatric consultation by the student health psychiatrist, and he admitted to being addicted to barbiturates. He also revealed that he had been depressed off and on since his mother's suicide when he was 13. He was encouraged to seek psychiatric help and asked to resign from the program until he had regained his health. One month later he was found in his apartment, having shot himself in the head with a shotgun. No suicide note was found, but it was learned from his father that he had recently broken up with an older woman his father had strongly disapproved of.

Case 4. Dr. D was a 32-year-old man who had graduated magna cum laude from a large eastern university and was at the top of his class in medical school, where he was elected to Alpha Omega Alpha. After medical school, he entered a residency in internal medicine and married. His impulsiveness and immaturity involved him in some difficulties, however, and he was finally asked to resign from a fellowship in a medical specialty. He then began a private practice in general medicine. He entered psychotherapy because of severe marital problems and excessive use of barbiturates. His psychiatrist was also the director of the residency program he later entered. During his 2 years of psychotherapy, he divorced his wife and stopped using drugs. He was accepted for residency on the recommendation of the training director, who was fully cognizant of his emotional problems. It was decided to "take a chance on him in view of his intelligence, sensitivity, and many assets." In his first year of residency, he discontinued psychotherapy because of his rotation to a state hospital for a 6-month period. Without apparent reason, he committed suicide by an overdose of barbiturates. He left no suicide note.

Case 5. Dr. E was a 34-year-old divorced man who was accepted for psychiatric residency in a university-affiliated Veterans Administration program. He had graduated magna cum laude from a large eastern university where he was elected to Phi Beta Kappa. He became severely depressed after his third year of medical school, dropped out, and was hospitalized for almost a year and treated for his depression. He was then able to return to medical school and graduated without difficulty. He interned in a large private hospital, after which he began a general practice, got married, and began psychoanalysis. He had been in psychoanalysis for about 8 years when he first applied for a psychiatric residency. He was open about his marital difficulties, his tendency to drink too much, and his previous mental illness. He was given a 5½-hour battery of psychological tests by a clinical psychologist and was interviewed by several faculty members. The psychologist reported that the test results indicated "immaturity, extreme ambivalence, and a significant tendency to act out." Her tentative diagnosis was "question of manic-depressive illness." As a result, he was not accepted into the program. This led to a long series of interactions between program staff and Dr. E, including his being allowed to talk to the psychologist and his request that the psychological tests be given to his psychoanalyst, which was granted. He then reapplied for the following year, supplying more than 18 letters of recommendation from colleagues and from his psychoanalyst. The admissions committee relented, as did the psychologist, who admitted she could have been mistaken. He resigned after 6 months following a bitter and hostile divorce from his wife. Faculty evaluations stated, "Highly intelligent, idealistic. Has difficulty compromising, however." One supervisor noted that he was stubborn and very angry. He discontinued his psychoanalysis at the time of his resignation. He was found dead 2 months later from a gunshot wound in the head, having left no suicide note.

POSSIBLE CAUSAL FACTORS

Suicide in the Gifted

There can be little dispute over the observation that this group of residents was gifted. They were intelligent, motivated, sensitive, and creative individuals, most of whom had graduated magna cum laude and were elected to Phi Beta Kappa. It is well known that college graduates are more likely to commit suicide than *non*-graduates, but it is not known why this is true. Ross (7) has described this phenomenon in his work on physician suicide, providing the following "composite picture" of the suicide-prone physician: "graduated at or near the top of high prestige medical school class, and now he practices a peripheral specialty associated with chronic problems where satisfactions are difficult and laggard."

Shneidman (8) studied some of the suicides among a group of 1,500 high-IQ subjects in a special longitudinal study. Using the concepts of perturbation and lethality, he was able to correctly identify 4 of the 5 suicides in a blind clinical analysis that was based on an enriched sample. He found the clues of instability, early trauma, and lack of inner and outer controls to be especially important.

Marital Conflict

It is widely known that physicians as a group have a disproportionate incidence of marital difficulties. Vaillant and associates (9) wrote of the psychological vulnerabilities of physicians, indicating that almost half of their sample group had poor marriages or were divorced, compared with less than a third for a control group. Added to this vulnerability is the effect of psychiatric training on the marital relationship (10).

It is also known that a supportive relationship with a "significant other" is an important variable in suicide prevention. Shneidman noted this in his study of suicide in gifted individuals (8). Coombs and Boyle (11) have made a compelling case in favor of marriage as a "buffer" against emotional stress in medical training. It is striking that not one of the five psychiatric residents we have described was married or involved in a significant relationship with another person at the time of his death.

Age

According to figures from the American Psychiatric Association, 58 percent of all psychiatric residents are over the age of 30 (12). It is known that suicide among physicians increases with age (1). We were impressed with the youthfulness of our sample group (mean age= 29.8). Freeman (6) also noted that one of every three psychiatrist suicides is under the age of 40. It would appear that the most lethal period for psychiatrists is one that has been described by Gould (13) as a very important

transition point in which the individual moves from a cursory endorsement of introspection to taking a genuine look at himself.

Psychiatric Illness

Both Vaillant and associates (9) and Ross (7) pointed out the high incidence of drug and alcohol use among physicians. Among the residents identified as having substantial emotional problems in our previous survey (4), 10 percent were known to have a problem with abuse of these substances. Vaillant and associates also noted the high incidence of psychiatric hospitalizations among physicians. Ross discussed the prodrome of neglect of practice and depression that typically precedes physician suicide.

We were impressed by the degree of psychopathology in the residents in our sample, which was indicated by such problems as drug abuse, previous hospitalizations, previous intensive psychotherapy, absence of close personal relationships, and identity and role diffusion. We urge that the evaluation process pay closer attention to these clues and that the resident at risk be identified as early as possible.

The Process of Psychiatric Education

Many authors have discussed the effect of psychiatric education on the personality development of residents. An earlier study (14) reviewed the literature and discussed the increase in depression during the first year of residency training. Woods (15) discussed the identity diffusion that occurs during the first year of residency and the lack of support offered by friends, family, and even the program itself. Freeman (6) also touched on aspects of the young psychiatrist's vulnerability. Worby (16) commented on the effect of the system of psychiatric care—i.e., the confusion of the medical model and the discordant voices of consumers, government agencies, and various professional organizations—on the emotional well-being of the psychiatric resident. He and Mendlewicz and Wilmotte (17) considered psychiatric residents to be an extremely high-risk group.

All of the residents in our sample who committed suicide were from university programs. Moreover, our earlier nationwide survey (4) revealed that the four psychiatric resident suicides in the United States in 1971–1972 were from university programs. This is in no way a criticism of these large, competitive, and academically oriented institutions, which naturally attract highly intelligent, academically gifted residents like those in our sample group. We are merely emphasizing that these programs need to be more attentive to the emotional problems in their group of gifted residents.

POSSIBILITIES FOR SUICIDE PREVENTION IN PSYCHIATRIC RESIDENTS

The Selection Procedure

The question of preselection screening is invariably a concern of psychiatric educators. Ekstein (18) recently deplored the "primitive selection procedures" in most training centers. The difficulties described by Holt and Luborsky (19) 20 years ago remain to trouble us. No scientifically valid methods are available to screen out the potentially suicidal or disturbed resident.

Garetz (20) confirmed the difficulty in using psychological testing (in this case, the Minnesota Multiphasic Personality Inventory) as an absolute screen. Our survey of current practices in the United States (4) indicated that virtually none of the residency programs used psychological testing in evaluating applicants for residency. In our group of suicides, one resident had undergone considerable psychological testing, which led to his initial rejection. However, the psychologist was influenced to disregard her own data as a result of prolonged personal contact with the resident. Shortly before his death she wrote, "This resident's progress had made me realize the futility of psychological testing in the screening of applicants for psychiatric residency training."

Letters of recommendation are used by all programs, yet only 30 percent of the training directors feel that they are very useful (4). We were impressed by how often past problems were glossed over in letters from deans of medical schools and department chairmen. In one case vital information about a previous psychiatric hospitalization was withheld. We feel that letters of recommendation from deans and medical faculty are of little use in identifying the potentially troubled resident.

Interviews by faculty and staff members are used with great frequency and are felt to be somewhat more valuable than letters and to have good predictive value (4). These interviews customarily occur between 10 and 20 months before the residency year begins. Only three of the five residents in our suicide sample were interviewed by several staff and faculty. In three cases, the interviews or contacts had occurred more than 12 months before residency began, and in one case the lapse had been 24 months. In each of these cases, there were noticeable changes in mental status between the time of the interview and the beginning of the residency. We urge that every applicant be interviewed by several faculty members, but we wonder about the diagnostic or predictive validity of such interviews when they occur 1 or 2 years before residency.

The use of interviews by residents has been gaining popularity in recent years. In our survey, 90 percent of the programs used resident interviews in the application process and 84 percent found them to be of moderate to high value (4). In this study, none of the residents who later committed suicide was interviewed or evaluated by peers. On the basis of personal experience and review of these five cases, it is our recommendation that resident input should be used in every case. Although residents do not have the experience or knowledge of the staff, they often tap a dimension of the applicant's personality that may have eluded the faculty member.

Although there were obvious failures in the evaluation and selection of the five psychiatric resident suicides in our study, we wonder whether any single "correct" selection procedure could have prevented these deaths.

Supervision, Preceptorship, and Psychotherapy

Our survey indicated that supervisors' evaluations of psychiatric residents were used by almost all programs (4). Characteristically, they included an evaluation of the resident's personality as well as his developing skill and knowledge. Peer supervision was used in very few programs. Many programs (82 percent) provided faculty preceptors, who take a more personal interest in individual residents over the entire period of the residency. However, most programs leave the matter of personal psychotherapy or psychoanalysis largely up to the individual resident and neither require nor provide it (4).

The supervisors' evaluations of the residents in the suicide sample were generally helpful in alerting the training director to the residents' problems. In two cases, the residents resigned from the programs shortly before their suicides. In one case, the resident was dropped from the program and transferred to another. In no cases did the program provide psychiatric treatment. Although treatment was recommended in every case, the residents did not follow through, and none of them was actively involved in any psychiatric treatment at the time of his suicide.

None of these residents was supervised by a peer or involved actively with a preceptor. In three of the cases, fellow residents were aware of the drug abuse, but they said nothing about it. After one of the suicides, several residents commented, "We all knew he was sick. Why didn't somebody do something about it?"

This brings up the issue of responsibility. If a resident developed acute appendicitis during the course of his first year, would a program drop him, put him on probation, or let him resign without receiving medical attention? Or would the program provide him the necessary medical care through a health insurance plan or out of professional courtesy? In the absence of a family member or close friend, would a faculty member or fellow resident not have stepped in to offer assistance and support? Perhaps this is the most critical question to emerge from our analysis of these five cases.

We believe that the faculty bears some of the responsibility and that every resident should be given an individual faculty preceptor. Residents at risk should not be rotated away from their home facility during the first year. Supervisory evaluations should be conducted early in the first year to alert the administration to any problems. Supportive resident or peer groups should be formed to provide close peer contacts and foster a collective sense of responsibility. No resident should be discouraged from entering personal psychotherapy. Furthermore, if psychotherapy is indicated, the training director or preceptor should offer encouragement and provide referrals. If possible, no emotionally troubled resident should be permitted to resign or be dropped from a program before these measures have been taken. If possible, the troubled resident should be reassigned or placed on sick leave until such time as a more humane disposition is made or he is reinstated.

Menninger (21) stated that one of the major problems in suicide prevention is the denial of suicidal behavior on the part of the physician. It is of utmost importance that the training director, faculty, and residents be aware of these behaviors in their colleagues and that they personally encourage them to obtain prompt and competent assistance.

CONCLUSIONS

Sometimes very large changes in the algebra of life and death result from small changes in each factor of the equation. We propose the following equation for suicide in psychiatric residents:

> Primitive selection processes + high-risk group + high intelligence + history of mental illness + impulsivity + abuse of drugs or alcohol + lack of support from spouse, peers, or faculty + stress of psychiatric residency education + lack of adequate program intervention → suicide.

Who knows whether or not a small change in one or more of these factors might have saved any one of the five lives we have described? It is up to all of us involved in psychiatric education to try to find answers that will prevent the lethal outcome in this equation.

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Workshop on Writing for Scientific Journals

The 1975 annual meeting of the American Psychiatric Association will feature the second annual workshop on writing for scientific journals, to be held from 9 a.m. to 5 p.m. on Sunday, May 4 (the day before the annual meeting begins). The workshop, cosponsored by APA and the American Medical Writers Association (AMWA), will offer practical information and instruction on four subjects: common writing faults, organizing medical reports, getting your words on paper, and submitting a manuscript. Work assignments, which will be sent to registrants before the meeting, will form the basis for initial discussions during the workshop sessions. The course will begin with brief introductory lectures by the AMWA faculty, who include Charles G. Roland, M.D., chairman of the Department of Biomedical Communications, the Mayo Foundation; Barbara G. Cox, medical writer, Instructional Development Section, the Mayo Foundation; and Martha Tacker, Ph.D., free-lance medical writer and editor. Following the lectures there will be small group discussions on the four basic subjects. The workshop will conclude with a panel discussion in which participants will have the opportunity to question the editors of several psychiatric journals.

Registration is limited to 40 participants. All applications for participation must be received by April 7; the registration fee is $65. For further information on registration write to Charles G. Roland, M.D., Department of Biomedical Communications, the Mayo Foundation, Rochester, Minn. 55901.

Outpatient Alcohol Detoxification: Initial Findings on 564 Patients

BY DANIEL J. FELDMAN, M.D., E. MANSELL PATTISON, M.D., LINDA C. SOBELL, THERESA GRAHAM, R.N., AND MARK B. SOBELL, PH.D.

The authors report on a large-scale outpatient alcohol detoxification program, presenting a clinical rationale for outpatient detoxification, describing the program method, and giving initial evaluation data on the first 564 patients. Only 47 percent of the patients required detoxification, and only 19 percent of these required inpatient care. The majority of the patients successfully completed outpatient detoxification; half of these continued in the related rehabilitation program. There were no fatalities. The authors believe the results support the utility of outpatient detoxification as a cost-effective alternative to inpatient detoxification for the majority of acute alcoholics.

THIS PAPER REPORTS our experiences in innovating a formal large-scale outpatient alcoholism detoxification program. Our purpose is threefold: to present a clinical rationale for outpatient detoxification, to describe our clinical program, and to give initial evaluation data on the first 564 patients treated.

PROGRAM RATIONALE

The alcoholism withdrawal syndrome is a complex and potentially dangerous medical problem (1). It can be divided into the three following components:

1. The acute withdrawal phase. In this phase, primary problems involve acute toxicity and the consequent central nervous system dysfunctions that appear 24 to 48 hours after blood alcohol levels drop. Hallucinosis, delirium, toxic psychosis, and toxic death (the mortality rate is 6 to 16 percent) are the severe consequences (2). However, most individuals do not suffer serious withdrawal problems.

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6-10, 1974.

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The authors would like to thank Jerome Speaker and Linda Baker for their assistance in data tabulation.

2. The subacute phase. General dysfunction of major organ systems, secondary infections, and psychological symptoms that include depression, anxiety, and agitation may follow the acute phase or may appear without preceding acute symptomatology.

3. The chronic phase. In this phase, withdrawal involves the psychological features of drug dependency and the associated psychosocial conflicts and life dysfunctions.

Alcoholism services in general often fail to see the problem of withdrawal as a continuum; hence there is no effective linkage between treatment for acute withdrawal and the subsequent treatment phases (3).

EXISTING ACUTE TREATMENT FACILITIES

Plaut (4), reporting for the Cooperative Commission on the Study of Alcoholism, stated that acute alcoholism services are provided in six principal settings, each of which has major deficiencies. We shall briefly review the deficiencies associated with each setting.

Because of social stigma, formal reluctance, and informal mores of practice, the diagnosis of an alcoholic hospitalized voluntarily by his private physician will probably be recorded as acute malnutrition, avitaminosis, dehydration, gastritis, or the like. Typically, no formal alcohol history will be noted on the patient's chart, and he is handled as a medical problem. Perfunctory attention is given to his alcoholism per se. Treatment stops there, for only in a few exceptional hospitals is there any programmatic effort to address the alcoholism and to move the alcoholic from the hospital to community treatment resources.

The same negativistic attitude is found on psychiatric services throughout the general hospital. The treatment program is not geared to the needs of the alcoholic; he is usually the odd man on the ward. Since admission is for presumptive psychiatric symptoms, once those symptoms subside the alcoholic is discharged. Again, no provision for continuing treatment in an alcoholism program is made.

Nonhospital detoxification units often do not have 24-hour physician coverage and offer marginal nursing care. They often become "revolving doors" that see a dreary succession of the same faces because they do not have the resources to deal with the complex social, vocational, and daily support problems that their clients present. Other than providing a "sober-up" service, they are dependent upon other medical services for other than moderate withdrawal symptoms.

Most mental hospitals do not view their mission as providing acute crisis treatment, especially for the alcoholic. Voluntary admission will be accepted, but the alcoholic will usually not be urged to stay when he sobers up and asks to leave. In short, the mental hospital is oriented toward the acute psychotic, not the acute alcoholic.

While some of the programs in special alcoholism wards are exceptionally good, on the average they have a high recidivism rate. The hospital provides a temporary shelter. The ticket for readmission is intoxication, so the alcoholic returns again and again in an acute stage of inebriation to present himself for more sheltered "treatment." A major problem is the failure to establish a linkage between the hospital phase of treatment and the processes of rehabilitation in the community.

The vast majority of acute alcoholism problems are handled in the "drunk tank." In the worst instances, dehumanization, neglect, and death due to unattended medical complications occur in this setting. The best programs have medical consultation and humane care. However, jails are ill-equipped to offer treatment. Our jails are filled with public intoxication cases; these people do not need to be in jail.

NEED FOR COMPREHENSIVE ALCOHOLISM SERVICES

Although outpatient clinic programs might provide acute services in theory, in practice they do not. Cahn (5) reported few "walk-ins" for any clinic in his national survey. Usually such clinics are not staffed or equipped to provide acute treatment services. Thus they cannot provide for continuity of treatment.

Ideally, the alcoholic should have immediate entry into a treatment system at the time he experiences acute symptoms. He should receive appropriate care throughout the acute withdrawal phase and then proceed into the chronic phase of rehabilitation (6–8). Chafetz (9) noted "the necessity for a continuous, nonfragmented, non-rejecting relationship which requires in the initial stages of treatment an active reaching out to the patient" (p. 129).

Acute treatment facilities for alcohol detoxification have acquired a bad image. They are seen as revolving doors in which there is a high recidivism rate and where little rehabilitation is accomplished with the alcoholic client (10). In large part this is due to the fact that most detoxification centers have been located and designed to serve the person from skid row who has been arrested for public intoxication. Yet the skid row alcoholic represents only 5 percent of alcoholics, and only 5 percent of skid row habitués are alcoholic. The public intoxicant does need a supervised location to sober up, but he rarely requires detoxification (11). Further, the skid row clientele require major services in terms of social, vocational, and medical support that a detoxification center is not equipped to provide. Thus the appropriate service for the skid row population is usually not a detoxification center but a social reception center (12).

Most alcoholics exist in some type of stable framework. Only during periods of intensive drinking and related life crises do they seek treatment. Thus acute alcoholism is a spur to seek treatment, a ticket for admission, and an opportune time to establish effective treatment rapport. It seems good clinical sense to make acute alcoholism treatment an integral part of a total alcoholism service rather than a fragmented prelude to alcoholism services. Along these lines, Chafetz (9) proposed a model comprehensive alcoholism service center that would begin with acute treatment.

The evaluation of alcoholism services of the Joint Information Service of APA and the National Association for Mental Health came to much the same conclusion (13). This report noted,

> Because many alcoholics would rarely if ever need inpatient care provided other kinds of services were readily available, the community-based outpatient clinic can be legitimately considered the backbone of alcoholism services. (p. 29)

PROGRAM DEVELOPMENT

The Orange County Department of Mental Health established a funded alcoholism program in 1970 under the direction of one of us (E.M.P.). There were no public and few private alcoholism services in the county at that time. An initial community survey of needs and resources revealed the total absence of medical detoxification services as well as of counseling and rehabilitation resources. Program development focused on combining alcoholism services for the acute, subacute, and chronic phases.

First, component staff patterns were established for the needs of each of the three phases of alcoholism treatment. Nursing and medical personnel were provided for assessment and management of acute alcoholism problems. Paraprofessional staff were provided for initial intake, socialization, and program involvement during the subacute phase. Some paraprofessional staff continue in ongoing rehabilitation treatment responsibilities. In addition, professional staff for intensive psychotherapy, behavior modification, and vocational counseling were provided.

Second, negotiations were made with several new private inpatient alcoholism programs to provide acute medical inpatient care, and several halfway houses provided temporary housing and/or a recovery station where alcoholics could sober up.

Third, a program plan was developed to offer immediate access to treatment for all acute alcoholics on an ambulatory basis. Backup medical inpatient and recovery station services were to be provided through independent community resources; the outpatient center would then combine acute treatment services with immediate involvement in a rehabilitation program. A theoretical model for such a comprehensive community alcoholism service is provided elsewhere (14).

This report deals with the initial program and the first 564 patients. After his appointment as director, the first author (D.J.F.) extended and refined these procedures. A

subsequent report will provide data on procedural modifications and evaluations for 2,000 consecutive patients.

PROGRAM DESCRIPTION

All patients in our program are voluntary. They are usually referred from a variety of community and county sources. Any patient can present himself without an appointment during operating hours. Initial screening is conducted to determine if the patient is appropriate and eligible for service. Individuals are not accepted if they are not residents of Orange County or if they refuse to sign voluntary consent for treatment. They are also not accepted if a clinical evaluation indicates a primary problem other than alcoholism. Persons not accepted are assisted in obtaining service from the appropriate treatment facility.

Criteria for Clinical Management

When a patient is accepted at clinic intake, a routine initial blood alcohol concentration breath test (BAC) is taken.[1] If the client has no history of immediate drinking, his BAC is zero, and he shows no signs of withdrawal, medical evaluation is bypassed and the client enters the rehabilitation program. However, if his BAC is elevated or he complains of any withdrawal symptoms, the patient is referred for medical evaluation before his entry into the rehabilitation program.

Medical evaluation is based on assessment of both the clinical state and the BAC. Because of the known high tolerance to alcohol in alcoholics, we do not depend solely on clinical symptoms (15). Thus a patient with a BAC of over .10 is routinely observed on site and monitored with sequential BACs until the BAC drops below .10.

The criteria for clinical management are outlined in table 1. A patient with minimal clinical withdrawal symptoms and a BAC of 0 to .10 is not considered in medical danger. After medical evaluation, this type of patient is returned to intake for entry into the rehabilitation program the same day.

A patient with minimal withdrawal symptoms and a BAC of .10 to .30 is retained in the medical unit for observation and sequential BACs until it drops below .10. Outpatient detoxification procedures are initiated if this is clinically indicated. The patient is then returned to intake for triage into the rehabilitation program the same day.

Simple intoxication is clearly separated from clinical withdrawal symptoms. If there are clinical signs of simple intoxication without withdrawal symptoms, regardless of blood level, or if the BAC is over .30, regardless of degree of intoxication, the patient is remanded to his home or to a recovery station in the community to sober up. The family at home or the staff at the recovery station are alerted to the patient's condition and advised to return the patient if withdrawal symptoms appear. The patient is given a return appointment for medical and intake evaluation the next day when he is sober.

TABLE 1
Criteria for Medical Triage

Description of Clinical Withdrawal Symptoms	Blood Alcohol Concentration (BAC)	Initial Treatment Decision
Minimal	0	Return to rehabilitation intake
Minimal or none	Less than .10	Return to rehabilitation intake
Minimal	.10–.30	Medical observation; BAC monitor until BAC is less than .10; detoxification regimen; return to rehabilitation intake
None	.10–.30	Remand to home or recovery station to sober up; alert caretakers; set intake appointment for when sober
None (whether clinically intoxicated or not)	More than .30	Remand to home or recovery station to sober up; alert caretakers; set intake appointment for when sober
Moderate: psychomotor agitation, modest elevation in blood pressure, somatic complaints	Any level	Medical observation; BAC monitor until BAC is less than .10; detoxification regimen; return to rehabilitation intake
Severe: hallucinations, severe psychomotor agitation, convulsions, disorientation, marked elevation in blood pressure	Any level	Hospitalization

Patients with moderate clinical withdrawal symptoms, regardless of BAC level, are retained in the medical unit for observation and sequential BAC monitor. The patient is retained until clinical withdrawal symptoms moderate and the BAC has dropped below .10. Whenever possible this type of patient is then moved immediately into the rehabilitation program. Outpatient detoxification procedures are initiated and the patient is followed regularly in the medical unit while concomitantly involved in the rehabilitation program.

Patients with severe clinical withdrawal symptoms, regardless of BAC, are remanded for hospitalization. However, on occasion patients with severe symptoms refuse hospitalization; these have been managed on an outpatient basis. The highest BAC obtained thus far in a successful outpatient detoxification was .53.

Referral to a private contracting alcoholism hospital is recommended if any of the following symptoms or combination of symptoms are considered clinically incompatible with outpatient detoxification: hallucinations, disorientation, impending delirium tremens, severely elevated blood pressure, acute emotional crisis posing a risk to life functions, or severe concomitant medical illness.

[1]The BAC is determined by means of a gas chromatograph analyzer manufactured by Lucke Laboratories, San Bernardino, Calif.

Clinical Management

The acute detoxification services are provided by a staff of registered nurses with a physician consultant always available. A nursing assessment evaluates current physical withdrawal symptoms, current emotional stability, and associated medical complications. This assessment typically takes 30 to 40 minutes. A clinical treatment decision is then reached, with physician consultation if required. The medical unit retains and monitors the patient if necessary and returns the patient to initial rehabilitation program intake if possible. If the decision is for outpatient detoxification management, the alcoholic is provided with day-to-day medication management. Medication includes minor tranquilizers and anticonvulsants as indicated.

After careful observation and BAC monitor indicate that the patient may be released, he is given a return appointment for the next day to see one of the nurses on duty. The next visit also involves an evaluation by a nurse and appropriate medication and observation. Visits may be daily or spaced according to clinical indication until the patient is no longer symptomatic.

As noted, every effort is made to integrate the detoxification program into the rehabilitation program from the moment the acute alcoholic presents himself. The alcoholic is immediately met by an intake alcoholism counselor. This counselor obtains an assessment of the alcoholic's clinical state. An alcoholism history as well as personal, family, social, medical, and vocational histories are also obtained. If medical evaluation is required, the alcoholic is taken to the medical unit. After release from the medical unit, the alcoholic returns to the intake counselor, who then collects any intake data not obtained previously.

The intake counselor introduces the new alcoholic patient to one of the daily "new patient groups." This group provides an orientation to the clinic and a brief discussion about the nature of alcoholism and the goals of rehabilitation. The new alcoholic returns daily to the new patient group for more didactic information, socialization with other new patients, and involvement with the problem of alcoholism that is kept at a low level of emotional intensity. At the same time the new alcoholic is introduced in the Social Learning Center (SLC). The SLC provides an opportunity to meet alcoholics involved in rehabilitation, reading, recreation, and informal learning activities that focus on interaction with others in appropriate everyday activities. Emphasis is given to the experience of normal daily interaction.

Within the first week the intake counselor reviews the initial status of the new alcoholic at a staff conference, presenting a preliminary report of family resources, requirements for food, clothing, and housing, and needs for psychological, social, medical, and vocational services.

By the end of the second week the new alcoholic has usually passed through the subacute phases of withdrawal and has experienced intensive participation in the new patient group and in SLC activities. A second case review is made at this time and a definitive treatment plan is negotiated with the alcoholic client. Subsequent rehabilitation based upon individual needs for psychological, medical, social, and vocational services is then initiated.

Thus when he first presents himself for treatment, the acute alcoholic enters a total treatment program that simultaneously involves necessary acute detoxification services, subacute management, and immediate triage into a sequential rehabilitation program.

PROGRAM RESULTS

Data for this study were derived from a systematic review of the charts of all of the first 564 consecutive patients who entered the program. A data management information system is employed by the program; standard demographic and symptom data information are therefore uniformly collected. A standard treatment form is completed for each treatment contract; this allows uniform reporting of patient status and recommended treatment. The requirements for initial detoxification, continued detoxification treatment, and completion of detoxification treatment are reported in a standard fashion. Failure to follow treatment recommendations is noted in this system. In this study, all patients who completed detoxification were routinely followed for four weeks in the data system to determine continued participation in treatment.

The demographic characteristics of our patient population are presented in table 2. The mean age of our subjects was 43 years; the age range was 20 to 72. The relative minority of women may not represent the actual prevalence of women alcoholics. Rather, it may represent the oft noted fact that women underutilize alcoholism facilities. The race distribution is proportional to population figures for Orange County. However, this may not represent the racial distribution of our target alcoholic population. The figures for age, education, and marital status are similar to those in other alcoholism outpatient populations (7, 8, 16).

The duration of abnormal drinking indicates that the majority of patients had stable living situations, whereas the alcohol-related characteristics indicate long-standing alcoholism problems. The mean number of years alcoholism had been a problem for the total sample was 19.8; the range was 0 to 43. The figures related to social difficulties (arrests) suggest an alcoholic population that has significant social pathology. In part this is a result of the fact that a high number of transient, socially unstable patients were referred to the clinic when it was first in operation. Data gathered for our proposed study of 2,000 patients indicate a decreasing proportion of socially unstable patients.

The breakdown of indications for detoxification are as follows: Less than half of the 564 acutely alcoholic patients (267 patients, 47 percent) required detoxification. Thirty-four patients who required detoxification were women (35 percent of the women in the total sample), and 233 were men (50 percent of the men in the

total sample). Only a small minority of those who required detoxification needed inpatient care (50 patients, 19 percent of all those who required detoxification and 9 percent of the total sample). Most of the patients who required detoxification were treated on an outpatient basis (217 patients, 81 percent of all those who required detoxification).

Of note is the fact that 82 percent (178 patients) of those who began outpatient detoxification returned regularly to complete this phase of treatment (the mean number of visits for successful outpatient detoxification was three). Twenty-eight patients required two detoxifications, 5 required three, and 3 required four. Thus of all those who required detoxification, only 36 (17 percent) were recidivists; 108 (50 percent) continued in treatment. The mortality rate for the total sample was zero.

TABLE 2
Demographic Characteristics of 564 Acute Alcoholic Patients

Characteristic	Number	Percent
Sex		
Male	469	83.0
Female	95	17.0
Education		
Less than high school	186	33.0
High school	162	29.0
Beyond high school	214	38.0
Marital status		
Single	61	11.0
Married	202	36.0
Separated	78	14.0
Divorced	196	35.0
Widowed	26	4.0
Race		
White	499	88.0
Black	9	2.0
Spanish	54	9.5
Indian	2	.5
Maintenance of permanent residence*	348	62.0
Alcohol-related arrests**		
No arrests	128	23.0
Arrests	366	65.0
Unknown	70	12.0
Alcohol-related hospitalizations***		
Never hospitalized	266	46.5
Hospitalized	296	53.0
Unknown	2	.5

*Of the 267 patients who required detoxification, 135 (51 percent) maintained a permanent residence.
**The mean number of alcohol-related arrests for the total sample was 5.3; the range, 0–110.
***The mean number of alcohol-related hospitalizations for the total sample was 1.3; the range, 0–21.

DISCUSSION

The first issue of note is that our clinical experience indicates that outpatient detoxification can be successfully conducted without undue morbidity or mortality.

Second, although our outpatient sample was taken from an unrestricted acute walk-in service, less than half of the patients actually required detoxification. This finding parallels that of Gross and associates (17), who reported that 52 percent of their sample of alcoholics hospitalized for acute services actually presented with toxicity syndromes. This suggests that inpatient detoxification services may be burdened with patients who might be handled on an outpatient basis and who are hospitalized only because the acute service is located in the hospital. This has cost-effectiveness implications: the cost for a hospital bed may be $100 a day; our total outpatient cost is approximately $20 per service day.

Third, our experience indicates that we reach a large number of alcoholics through our open-access acute services. Even though half of the patients did not require detoxification, their acute symptoms served as a ticket for admission (18).

Fourth, in this initial sample we had a relatively high proportion (38 percent) of socially unstable, high-risk patients. We expected these patients to have greater need for temporary supportive housing and more medical complications requiring inpatient care. Yet in the group requiring detoxification, only 19 percent required inpatient care. In this sample, 49 percent required supportive housing, but the data on 2,000 patients in our proposed study indicate that this figure will decrease. These figures, coupled with the low recidivisim rate (17 percent), suggest that the gloomy rehabilitation statistics for detoxification programs do not accurately reflect the inefficacy of detoxification procedures. Rather, rehabilitation failures represent the bias of a socially disabled skid row population or a detoxification program that is not equipped to phase into rehabilitation. Even with a relatively high-risk population at the outset, we have maintained a clinically viable program. Data from our larger sample indicate an even higher success rate than reported here.

Fifth, we consider the facts that 82 percent of the sample voluntarily completed detoxification and that of those, 50 percent continued in treatment to be an indication that the program is succeeding in "capturing" the acute alcoholic into a rehabilitation program. In comparison, Gerard and Saenger (16) reported that only 20 percent of "motivated" alcoholics returned after 3 or 4 visits. Gerard and Saenger also reported three variables that predicted a patient would stay in treatment, namely, 1) the patient received medications, 2) the patient was immediately involved in peer group activities, and 3) family and significant others were quickly involved in rehabilitation.

We have built each of these variables into our program. In terms of medication, we use a variety of medications relatively interchangeably. Both Victor (19) and Mottin (20) reviewed medical detoxification procedures and found little to support a specific medication or regimen. On the other hand, Kissin and associates (21, 22) reported the successful use of medication vis-à-vis placebo effect and transactional values. Their data identify a major group of alcoholics who respond positively to medically oriented, concrete treatment transactions but respond poorly to psychodynamic interventions.

The use of small amounts of medication on a day-to-day basis is often valuable in establishing and maintaining initial contact and treatment in addition to their specific effect. In terms of peer group involvement, even during the acute phase of withdrawal the alcoholic is introduced to and socially involved with peer alcoholics in the social rehabilitation center as part of acute treatment. In regard to significant others, we offer the opportunity for those who are significant to our alcoholics to become involved as soon as possible.

Finally, we wish to comment on the long-range rehabilitation implications of acute alcoholism treatment. For the 27 percent who did not complete detoxification and the 50 percent who did not continue into rehabilitation, did we offer any long-term significant intervention? Some data seem to suggest a positive answer. Ludwig and associates (23) found that patients discharged from a hospital continued to drink but showed significant life improvement. Gillis and Keet (24) reported that although 25 percent of their treatment group were negativistic, denial ridden, and uncooperative, on follow-up they were found to be significantly improved in adjustment.

Cahalan (25) reported that 15 percent of alcoholics move in or out of symptomatic alcoholism each year. Thus symptomatic intervention may restore coping ability. The epidemiological data of Edwards and associates (26) support this contention. Mello (27) reviewed evidence that alcoholic behavior is more pliable and changeable than thought, and Park (28) presented evidence that the irreversibility of alcoholism phases is not clinically accurate. Pattison and associates (29, 30) showed that major improvements in different areas of life adjustment do occur in spite of minimal or modest improvements in drinking behavior. More definitive answers depend on long-term follow-up studies; nevertheless, such evidence supports continued clinical trials with outpatient detoxification programs because they may have both immediate and long-term payoffs.

In summary, our data suggest that the need for inpatient detoxification facilities may not be as great as thought heretofore. Outpatient detoxification may be both a cost-effective and therapeutic alternative for a majority of acute alcoholics.

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Brief Hospitalization of Patients with Families: Initial Results

BY MARVIN I. HERZ, M.D., JEAN ENDICOTT, PH.D., AND ROBERT L. SPITZER, M.D.

A total of 175 newly admitted inpatients who lived with families were randomly assigned to three treatment groups: standard inpatient care (discharge at the therapist's discretion), brief hospitalization (one week or less) with transitional day care available, and brief hospitalization without day care. Outpatient aftercare was offered to all patients. The three groups showed no significant differences as to amount of improvement in levels of psychopathology at 3 and 12 weeks, but the briefly hospitalized patients were able to resume their vocational roles sooner. There were no significant differences among the groups in readmission rates.

IN RECENT YEARS there has been an increasing awareness of the potentially deleterious effects of prolonged psychiatric hospitalization, such as regression, damaged self-image, deterioration of role functioning, extrusion from the family, and loss of ties to community institutions. As a result, many psychiatrists have attempted to return hospitalized patients to the community as soon as possible. Although there are a number of reports on the benefits of brief hospitalization (1–5), there are few controlled studies in this area.

Caffey, Galbrecht, and Klett (6) reported that schizophrenic patients in a brief hospitalization group (29 days) exhibited somewhat more psychopathology at the time of their earlier discharge compared with schizophrenic patients in a standard hospitalization group (83 days), but at 6 months and 1 year after admission, they showed at least as much improvement in psychopathology. In addition, the briefly hospitalized group did not demonstrate a greater incidence of readmission or a significantly shorter mean time out of the hospital prior to first readmission. In a controlled study of patients who had recently been hospitalized, we (7) found that day hospitalization proved to be superior to inpatient hospitalization on most outcome measures. A major deficit of these studies is that they did not evaluate the effects on the patients' families.

In 1971 we began a project to study the following three basic issues with regard to newly admitted inpatients who lived with responsible adults: 1) the relative efficacy for the patient of brief hospitalization as an alternative to standard inpatient care, 2) the possible advantage for the patient of transitional day care following brief hospitalization, compared with direct discharge to the community, and 3) the evaluation of the impact of each of these programs on the patients' families. Intake to the study was completed on June 15, 1973. This paper will report the initial results regarding the patients. Subsequent papers will explore the impact on the patients and their families during a two-year follow-up period.

METHOD

Subjects

The study was conducted on the Washington Heights Community Service of the New York State Psychiatric Institute. The service is responsible for a catchment area with a population of 90,000 in an ethnically diverse lower-income area of upper Manhattan in New York City.

All patients admitted to the inpatient service were evaluated for possible inclusion in the study on the first weekday following their admission. The attending psychiatrist and the therapist (a psychiatric resident or psychologist) assigned to the patient carried out the evaluation. A total of 175 patients met the following criteria for inclusion in the study: 1) above 16 years of age, 2) living with a responsible adult, 3) having a functional psychiatric illness, 4) having no serious medical illness requiring hospitalization, and 5) not having a primary diagnosis of alcoholism, drug addiction, organic brain syndrome, antisocial personality, or adolescent behavior disorder.

Description of Treatment

Immediately after their evaluation for inclusion in the study, those patients who met the criteria were randomly assigned to one of the following three treatment groups:

1. Standard-out group (N=63). Standard hospital procedure was followed, i.e., the length of hospitalization was determined by the evaluation of the individual thera-

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pist. When inpatient care was no longer deemed necessary, the patients were discharged and followed, if appropriate, as outpatients.

2. Brief-day group (N=61). Every attempt was made to discharge these patients from inpatient care to aftercare within 1 week. The patients and their families were told that in all probability the patients would be discharged from inpatient care within 1 week but would receive appropriate aftercare services. When the subjects were discharged from inpatient care, they could receive day care unless it was considered unnecessary. There was no separate program for day patients. While at the hospital, they participated in the same program with the same staff as the inpatients. Discharge from day care was at the therapist's discretion, with outpatient treatment provided when appropriate.

Acceptable reasons for prolonging the inpatient hospitalization included suicide risk, possibility of violent behavior, and extreme disorganization. Whenever a patient could not be discharged within 1 week, the reasons were recorded on a form.

3. Brief-out group (N=51). The inpatient treatment for this group was identical to that of the brief-day group. Day care was not offered, i.e., brief hospitalization was followed by full discharge, with outpatient therapy when appropriate.

Once a patient was assigned to a treatment group, he was reassigned to the same group on subsequent readmissions during the entire follow-up period of 2 years after initial admission. All patients were treated on the same 55-bed inpatient ward, which has an open-door policy except for a closed 10-bed intensive care unit. Patients in the three groups were treated by the same staff and participated together in the same activities during the day. Ordinarily, the same therapist followed the patient from inpatient status to day, or outpatient, status. When the therapist completed his rotation on the service, the patient was transferred to an outpatient staff therapist.

The demographic and diagnostic characteristics of the patients in the three groups are shown in table 1. The only significant differences among groups were more men in the brief-out group than in the brief-day group and fewer married patients in the brief-out group than in either of the other two groups ($p<.05$, using two-tailed t test). There were no significant differences in any of the other prognostic variables measured, including duration of current condition; age when first hospitalized; adolescent and adult friendship patterns; overall academic and work performance; past hallucinations, delusions, suicidal attempts, and arrests; and clinical judgment of overall severity of illness from age 12 to 1 month prior to admission or during the month prior to admission.

TABLE 1

Demographic and Diagnostic Characteristics of the Three Treatment Groups, in Percents

Category	Brief-Day (N=61)	Brief-Out (N=51)	Standard-Out (N=63)
Age			
15–24	28	25	29
25–34	43	37	35
35–44	13	14	16
45–54	10	12	11
55 and older	6	12	9
Sex			
Male	34	55*	49
Female	66	45	51
Marital status			
Single	41	49	51
Married	43	27**	32
Widowed	3	6	0
Divorced	2	10	3
Separated	11	8	14
Previous admissions			
None	59	39	40
One	18	25	27
Two or more	23	35	33
Social class***			
I and II	15	12	3
III	25	16	19
IV	25	39	46
V	30	27	29
Uncoded	7	6	3
Religion			
Catholic	54	43	49
Protestant	28	29	29
Jewish	10	24	14
Other or uncoded	8	4	8
Race			
White	57	73	68
Black	43	27	32
Clinical Diagnosis			
Schizophrenia	66	60	63
Affective psychosis	14	18	15
Neurosis	2	12	13
Personality disorder	10	2	5
Other	8	8	4

*The brief-out group contained significantly more men than the brief-day group ($p<.05$).

**The brief-out group contained significantly fewer married patients than either of the other two groups ($p<.05$).

***According to Hollingshead and Redlich (8).

EVALUATION OF TREATMENT

The differential effects of these three treatment programs on the patients' psychopathology and social role functioning and the effects on their families were investigated by successive cross-sectional evaluation at admission, at 3 weeks, and at 3, 6, 12, 18, and 24 months after admission.

One of several research interviewers directly examined each patient using the Psychiatric Status Schedule (PSS) (9), a standardized research procedure. The items of the PSS can be summarized into four factor-analytically derived symptom scales and one scale of role functioning.

In addition, the research interviewer also made a summary judgment on the Global Assessment Scale (GAS) (10), an instrument designed to allow the rater to make an overall evaluation of a patient's functioning on a hypothetical continuum of mental health-illness. It uti-

lizes a single scale of 0 to 100, and the ratings are made by considering the patient's need for supervision, level of functioning, overt symptomatology, and level of subjective distress.

The patient's therapist recorded his description of the patient on the Mental Status Examination Record (MSER) (11), which is designed to enable the rater to record the results of a mental status examination.

In addition to the MSER, the therapist completed a supplement that covered role functioning and also made a GAS rating.

One of the research interviewers also interviewed a family member using the Family Evaluation Form (12). Data from this evaluation will not be reported in this paper.

In order to evaluate the relative use of therapist and social service staff time, each therapist and social worker completed weekly treatment reports for the first 12 weeks, indicating the amount of time spent with the patient and in dealing with his problems outside of the time spent in routine ward activities. In addition, a record was kept of all psychotropic medications prescribed.

RESULTS

Time Spent in the Hospital and in the Community

How successful was the staff in discharging the brief-day and brief-out patients within the specified time limit? Eighty-three percent of these patients were discharged within the specified time limit. For the remaining 17 percent (10 brief-out and 9 brief-day patients), there were clear-cut clinical contraindications against discharging them within the time limit, including suicidal behavior, delay in starting ECT, medical complications from psychotropic medication, and the family's refusal to accept the patient at home. The average lengths of inpatient stay for the brief-out and brief-day groups were 8.8 and 9.8 days, respectively.

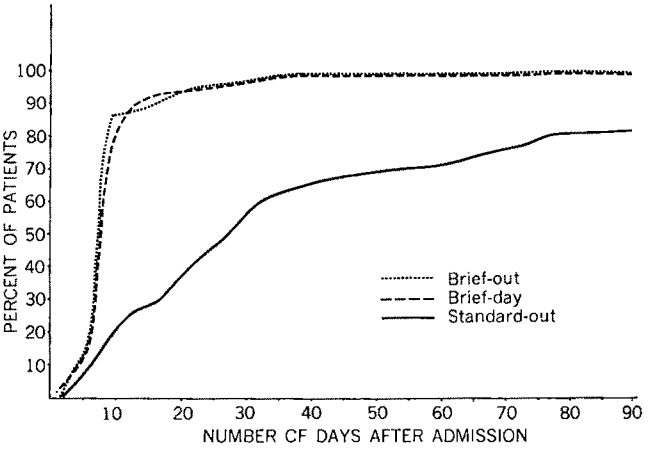
Since some patients were readmitted shortly after their first release, a more conservative measure of the length of initial hospitalization is the time from admission to the first significant release, which is defined as the number of days until the patient was discharged and remained in the community for at least 1 week. The average length of stay for the brief-out group was 10.8 days and for the brief-day group, 11.8 days. In contrast, the standard-out group's average length of stay to initial discharge was 50 days and to first significant release, 60 days (counting two patients still hospitalized when this report was written).

The difference in length of stay between the two brief groups and the standard group would have been even larger were it not for the fact that 9 standard patients signed themselves out of the hospital against medical advice, while only 1 briefly treated patient did so.

Since the distribution for the three groups is markedly skewed, it is useful to examine the median length of inpatient stay, which was 8 days for both brief groups for both initial and first significant discharge and 28 days for the standard group for both initial and first significant release. The data on length of hospitalization to first significant release are shown in figure 1.

FIGURE 1

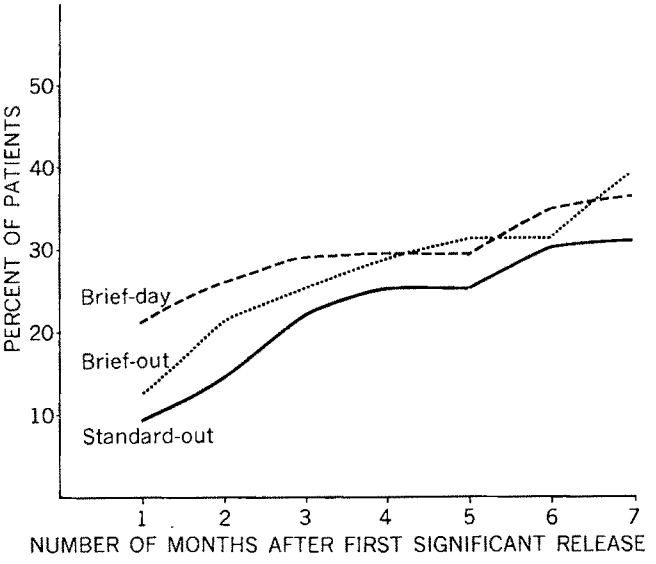
*Cumulative Percent of Patients Who Had Their First Significant Release from Inpatient Care Within the First 90 Days**



*Number of days from admission until the patient was discharged from inpatient care and remained in the community for at least 7 days.

FIGURE 2

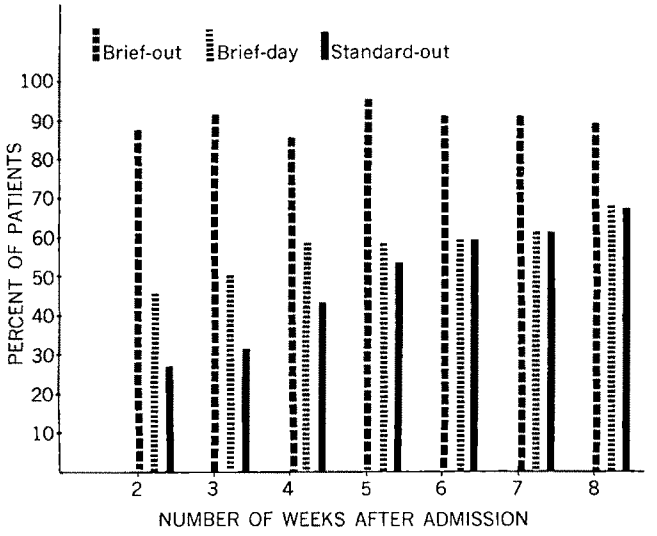
*Percent of Patients Who Were Rehospitalized Within 7 Months After Their First Significant Release**



*Calculated on the basis of the number of patients at risk for readmission during the full time period.

Did the readmission rates differ for the three groups? Figure 2 shows the percent of patients who were rehospitalized within the first 7 months following their first significant release. No differences were statistically significant. The readmission rate for the standard group was generally lower than that for both brief groups. The two brief groups were very similar. It is of interest that on the first readmission, the average length of inpatient stay was

FIGURE 3
Percent of Patients in the Community Full Time During the First 8 Weeks After Admission



25 days for the brief-out group, 13 days for the brief-day group, and 42 days for the standard group, with several of these patients still hospitalized when this report was written.

What percent of the subjects were inpatients at different follow-up points? While approximately 10 percent of both brief groups were inpatients the second through the eighth week, the percent of standard patients who were inpatients gradually declined from 73 percent at 2 weeks to 32 percent at 8 weeks.

How much time did the subjects spend on the average as inpatients during the first 90 days after admission to the study? For the brief-out group it was 15 days, the brief-day group, 14 days, and the standard group, 42 days.

What percent of the patients were living in the community full time at different follow-up points? (Day patients were not considered to be living in the community full time.) Figure 3 shows the percent of the patients in the community full time during the first 8 weeks after admission. By the second week, nearly 90 percent of the brief-out patients were in the community as contrasted with only 46 percent and 27 percent of the brief-day and standard patients. With each succeeding week, more patients from the brief-day and standard groups were in the community, but by the eighth week the brief-out group still had over 20 percent more patients living full time in the community.

What percent of the brief-day group actually used transitional day care? Only 32 of the 61 patients (53 percent) for whom day care was available used the service for even 1 day. Of those who did not use day care, 23 were directly discharged to outpatient care by the therapists because day care was not indicated, and 6 patients discharged to day care refused to attend and instead became outpatients.

The percent of patients who were actively in treatment (inpatient, day, or outpatient) at 6 months is as follows: brief-day, 74 percent, brief-out, 65 percent, and standard, 57 percent. Thus, contrary to the expectation that prolonging hospitalization would lead to more commitment to treatment, more brief patients were in active treatment at 6 months.

Measures of Psychopathology

At the present time, initial, 3-week, and 12-week evaluations have been completed on all of the patients. There were no significant differences on initial levels of psychopathology for the three groups on either the PSS or MSER scale scores. All three groups of patients improved on virtually all measures of psychopathology at 3 and 12 weeks. Analysis of covariance was used to evaluate whether the groups differed in the amount of improvement in psychopathology; there were no significant differences.

Only the Summary Role scale of the PSS showed a significant difference among the three groups ($p<.05$, two-tailed t test). At 3- and 12-week follow-up, the standard group showed more impairment in role functioning than did either of the brief groups. This was largely a function of the larger number of standard patients who were still in the hospital full time and therefore could not perform any role functions. Of those patients who would ordinarily be expected to work, only 13 percent of the standard group were working at 3 weeks, in contrast to 23 percent of the brief-out group and 30 percent of the brief-day group. For those patients who were actually fulfilling their roles as housekeeper, wage earner, or student at 3 weeks, the level of impairment was in the upper range of "mild," with no difference among the three groups.

Figure 4 contrasts the initial PSS scale scores for the combined study group on admission with the 3-week follow-up scores for each of the three study groups.

There were no significant differences between the GAS ratings made by the therapists and the research interviewers, and there were no significant differences in the amount of improvement among the three groups. The overall amount of improvement from time of admission to 12 weeks was statistically significant ($p<.05$, two-tailed t test) and of considerable magnitude. The overall average rating at admission was 31. This score is at the bottom of the range defined as "Major impairment in several areas such as work, family relations, judgment, thinking, or mood, some impairment in reality testing or communication, or single serious suicidal attempt." At 3-week follow-up, the average GAS score was 45, which is the middle of the range defined as "Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention. . . ." At 12 weeks there was further improvement in all groups, with the average GAS score increasing to 51, which is at the bottom of the range defined as "Moderate symptoms or generally functioning with some difficulty. . . ."

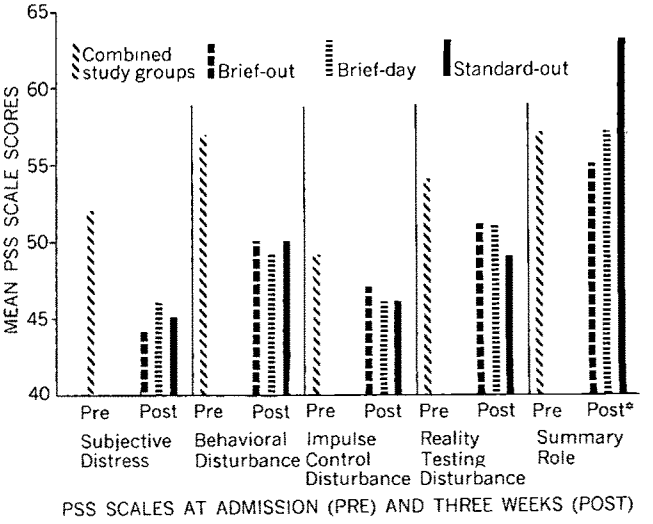
Relative Use of Staff Time and Medication

Did the staff spend more time with the brief groups during the first 3 weeks? Many staff members anticipated that they would have to spend more than the usual amount of time with these patients in efforts to ensure a speedier recovery and with their families in offering support and guidance in dealing with the patients' disturbed behavior. This expectation was not borne out with regard to primary therapists' time. During the first week the brief-day group took an average of 82 minutes of the social service staff's time, which was significantly more than the brief-out group (51 minutes) and the standard group (46 minutes) ($p<.05$, two-tailed t test). Thereafter there were no significant differences. The reasons for the greater use of social service time by the brief-day group are not yet clear.

Contrary to expectations, the brief groups received significantly less psychotropic medication during each of the first 12 weeks of the study ($p<.05$, two-tailed t test). This difference was particularly striking during the first week, when almost all patients were receiving psychotropic medication and the therapists might have been expected to use more medication to hasten the resolution of acute symptomatology in the brief patients.

FIGURE 4

Mean Psychiatric Status Schedule Scale Scores for the Combined Study Groups at Admission and for Each Study Group at 3 Weeks



*The brief groups improved significantly more than the standard group ($p<.01$).

DISCUSSION

In this paper we have attempted to answer the question: What is the relative efficacy of brief hospitalization (less than 1 week), with and without transitional day care, compared to standard hospitalization and discharge at the therapist's discretion, with all patients offered outpatient aftercare when appropriate?

All three groups made substantial improvement on measures of psychopathology, as evaluated by both the therapist and the research interviewer. There were no significant differences in psychopathology among groups at 3 and 12 weeks, indicating that the resolution of acute symptomatology was not affected by shortening the length of inpatient stay to about 1 week. Thus the results did not support either of these conflicting views: 1) that patients resolve their acute symptomatology faster if they are removed from the stressful life situation that may have been associated with the development of the present illness, and 2) that patients recover faster if they are quickly released from a regressive hospital environment. However, there was some evidence for the regressive effects of hospitalization within the first 60 days after admission to the study. While slightly more than half of the patients in each group spent at least 1 day in the intensive care unit, patients in the standard group averaged more than twice as long (8 days) in this unit for acutely disturbed patients.

While the three groups had almost the same level of psychopathology at 3 weeks, many more of the brief patients were able to resume their roles as wage earner, housekeeper, or student because of their early return to the community. Although there is no direct evidence, we assume that the earlier release, coupled with the statement from the therapist that only a week of hospitalization was expected, enabled many patients to return to jobs that they might have lost had their hospitalization been prolonged. In addition, it is likely that resuming one's major occupational role with only mild impairment has a positive effect on self-esteem as compared with the role of being a patient in a psychiatric hospital.

Clinical staff members are often reluctant to release a patient after only a short hospitalization because of their fear that there will be a greater likelihood of an early readmission. In this study, as in several others (5–7), the early hospital release was not associated with a significantly higher readmission rate. It is of interest that there was no evidence that the availability of transitional day care after a brief inpatient stay reduced the rehospitalization rate.

All of the patients in our study lived with their families or with an adult with whom they had a close relationship. Hence these findings may not apply to the large number of patients who live alone (31 percent of our admissions), many of whom are socially isolated. In addition, these findings may not apply to inpatient programs that have no aftercare components and therefore refer patients to another facility for aftercare. Similarly, these results may not apply to facilities that do not have the professional staff to provide the range of inpatient and aftercare services offered at our facility.

In this paper we have examined the early effects of brief hospitalization on patients with families. We have not yet examined the long-term effects on the patients or the effects on the families. However, the early results clearly suggest that for the patient, brief hospitalization is as good as standard hospitalization in terms of resolution of acute symptomatology and readmission rates and is superior in terms of role functioning and time spent in the community.

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The Pregnant Psychotherapist in Training: Some Preliminary Findings and Impressions

BY O. EUGENE BAUM, M.D., AND CHRISTINA HERRING

With more women entering general medical and psychiatric training, the more that supervisors and staff can understand the impact of the resident's pregnancy on the resident and others, the more helpful they can be to her and she to herself. The authors' work was done at what was formerly the Woman's Medical College of Pennsylvania, which has had a larger percent of women in psychiatric training than most programs. This report is derived from a pilot study on the pregnant therapist.

SINCE THE OPENING of our residency program in 1967, we have had 34 residents in the adult basic psychiatry program. Of these, 20 have been women. This is not surprising, since during most of that period we were still the Woman's Medical College of Pennsylvania and only became integrated as the Medical College of Pennsylvania two years ago. Of the 20 women, 7 (35 percent) became pregnant during their residency. As a result of this experience, the data that have been obtained by the senior author in his capacity as a training and supervising analyst, and the added stimulus of attending a panel on "The Analyst's Emotional Life During Analysis" in which one of the panelists, Dr. Kato van Leeuwen (1), talked about her experiences as a pregnant therapist and as a supervisor, we were encouraged to proceed with the study of the pregnant psychotherapist in training.

In order to minimize any female-male bias that might occur if a male interviewer were involved, the coauthor, a medical student with special training in sociology and psychology, did the actual interviewing. To promote anonymity, interviews were held with former residents in our program, as well as with residents who had been pregnant during their training in other programs. Other sources of data were the supervisees and analytic training experience of the senior author. We were particularly interested in the impact of the resident's pregnancy on her learning experience, on her patients and her handling of their reactions, on the staff and the resident's interaction with them (2), and on the supervisory experience. We were also interested in what could be learned that might be useful in the future for those women who become pregnant during their residency (3). With more women entering this professional area for training, such knowledge can be particularly useful (4).

Some of the material in this paper was presented at a panel at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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STRESSES IN THE FIRST YEAR OF RESIDENCY

At best, the first year of the psychiatric residency program is stressful. It is a year during which a great deal of unlearning as well as learning has to take place, particularly for those who have had an internship that consolidated their medical experience. Anxiety of a normal developmental type is mobilized as a result of the learning of a new discipline requiring a unique kind of professional identity that tends to differ from the physician medical model; at the same time, one has to learn how to handle the anxiety mobilized by very emotionally disturbed patients. The learning of psychotherapy itself is a very emotional experience, and it can stir up latent problems in the therapist. It was therefore particularly interesting to have an opportunity to interview women who had been pregnant during their first year of the program. We would expect that this would be an added stress for the individual, particularly if it were her first pregnancy.

One might wonder about the impact on a woman who enters a residency program while actually in the midst of a pregnancy. What might the implications be? Does it mean that she is able to take the pregnancy and her professional responsibility in stride and adequately handle both, as well as get good training experience? Or does it mean that she is practicing some kind of denial for which a "price" has to be paid by the patient, the resident (as a training experience), the staff, and the program? How would pregnancy during the first year affect the resident's learning experience? What is the impact on the patients who know that the resident will be leaving soon to have a child? How much of the resident's time and libido will be taken away from her patients? Once the resident has established her identity as a psychiatrist, thus feeling more secure, and has learned to appreciate the impact of transference, fantasy, and other unconscious factors in patients, she should be able to deal more effectively with the impact of her pregnancy on her patients. One would expect, therefore, that by the second and third year of training, the resident would have developed greater skills that would help her cope with this special situation and be in a position to be more helpful to her patients, as well as

make the residency a richer learning experience for herself.

Are there additional responsibilities that one must consider in a residency in psychiatry that would not pose similar considerations in a field such as pathology or even surgery or general medicine, where patient relationships are more likely to be of shorter duration but where physical demands, especially in the third trimester, may be more intense? Some of us have had experiences which underscored the fact that most new residents in psychiatric training do not appreciate the intensity and impact of the transference in psychotherapy. This is one of the most important things they begin to learn during the first year of training. Therefore, they cannot be expected to appreciate the psychological impact and implications of a pregnancy on their patients during their first year of training. What is the staff's responsibility in alerting applicants to these facts so they can plan accordingly when possible? If a resident becomes pregnant during the first year of training, what can the staff do to help minimize any problems that might arise for the patients, the resident, and the staff? These were some of the areas with which we were concerned as we undertook this study.

EFFECTS OF THE PREGNANCY

In this preliminary study we were able to sort out certain general factors as well as individual concerns. As one would expect, when pregnancy occurred during the first year of training or when a woman entered the program well along in her pregnancy, there was a marked tendency for her to be less involved in the more emotional interpersonal impact of psychotherapy, particularly as regards transference, transference fantasy, and hostility mobilized in patients. Each resident had different manifest responses to the pregnancy, according to her personality makeup and defensive operations.

However, there were certain things that were common to all. There was a strong tendency for the residents to deny that the pregnancy posed special problems for their patients or for themselves. At the same time, they met their need for support and attention by turning to their patients, and they sometimes tended to be disappointed at insufficient support from the staff. How much this reflected a problem on the part of the staff person and how much it reflected the resident's reaction to denial or her "business as usual" attitude is a moot point. The more intense kind of psychotherapeutic efforts that would encourage patients to face, deal with, and work out feelings regarding the pregnancy did not take place. One psychiatrist wondered whether the pregnancy might in some ways protect the resident against the more intense turmoil of the first-year growth process of a developing psychiatrist.

An important source of data were those residents who were undergoing or had undergone an analytic experience. During their interviews these women were able to share more of their subjective experiences and show greater awareness of the problems to which they had contributed, in addition to whatever contribution the staff had made (2). Furthermore, there was less tendency for them to simply view the situation as the patient's problem when the patient failed to deal adequately with the therapist's pregnancy.

In the first place, the residents in analysis reminded us that pregnancy is a profound physiological as well as emotional experience, especially if it is the first pregnancy. Size, weight, fatigue, nausea, and bouts of hunger and weakness may all have an important impact, varying in intensity with different women. Some of the residents had felt embarrassed and had tended to avoid wearing maternity clothes for as long as possible. The greater the professional conflict or problem with identity, the more significant was the problem.

The last trimester of pregnancy was seen as difficult by some because of muscle strain, edema, difficulties with urination, shortness of breath, and difficulties in sleeping and in movement. Fears of helplessness, fantasies about harm to self or baby during delivery, and the fear of the pregnancy's impact on professional activities were mobilized. All of these residents tended to agree that the last phase of pregnancy also brought more withdrawal of libido from patients and work; this impinged on the resident's learning experience, as well as on her psychotherapeutic sensitivity in her work with patients, and caused guilt feelings. These women also recognized the pregnant therapist's increased need for support and understanding. The fear from a professional point of view was well expressed by one person, who said, "I was afraid that my practice would fall apart and so I pushed harder."

ROLE OF THE SUPERVISOR

The supervisor has a unique opportunity to work with the pregnant supervisee. How soon do patients notice that their therapist is pregnant? How do they handle it? Why is it that in some instances all of the therapist's patients react early and are able to communicate something relative to the pregnancy, while the patients of other therapists say nothing for months or not at all, unless they are asked? In one supervisory instance the resident was finally encouraged between the sixth and seventh months to bring up the pregnancy for discussion with patients who had been avoiding it. There did seem to be a direct relationship between acting out on the part of the patients and their difficulty in coping adequately with the resident's pregnancy and dealing with their feelings and fantasies and the resident's tendency to deny the impact of the pregnancy on herself and on the therapeutic relationship. It was very helpful, therefore, to have the observations of those therapists who had had a number of pregnancies, including pregnancies during residency. They could look back from the perspective of multiple experiences and in some instances had had a personal analytic experience and could appreciate the impact that the pregnancy had had on their patients.

Supervisors' reactions to pregnant residents varied, of

course. One supervisor offered supportive help and interest, with decreased emphasis on supervision. In contrast, another supervisor had an overzealous desire to encourage a resident to look for and face the possible impact of her interaction with the patient and to thus face some of her own emotional responses in order to make it a more meaningful learning experience. Some supervisors showed countertransference responses by arranging supervision at times that were inconvenient for the resident, e.g., Saturday mornings. How much of this was the supervisor's problem and how much of it was a reaction to the resident's way of relating and communicating?

Years after her training, one former resident wrote to her supervisor, who was also a director of training, apologizing for the anger she had expressed during that period. It is interesting that she wrote at a time when she was taking care of her children full time, without any professional activity. In essence, she said that she had blamed all of the imperfections that she had encountered on the program, as if the program and her supervisor were to make up for all that was missing in the past—an obvious transference reaction in a basically good, mutually respecting, and fond professional relationship. The supervisor had noted the resident's diminished libido in regard to her work with patients, her reading, and her supervision, and undoubtedly this must have mobilized guilt reactions in the resident regarding her professional role. At the same time, a countertransference response was operating, for the supervisor had hoped that she would handle things differently than some of his other pregnant residents had.

First- and second-year residents often have problems with dropouts, transference-countertransference reactions, and in setting realistic goals. These learning experiences stir up anxiety and conflict. What happens, then, when another manifest and emotionally charged phenomenon takes place involving the resident—not the fantasy but the reality of pregnancy and sex? How does this impinge on the patient's fantasies, conflicts, and defensive operations, and how does it complicate the situation for the less experienced resident?

When there is more than one pregnant resident in the program, they can benefit by sharing their feelings and responses with each other. Other writers (2, 4) have noted that peer responses, as well as staff responses, may convey covert if not overt hostility. In some instances the others are reacting in terms of their own anxieties, professional demands, and jealousy, but at other times, one wonders how much of this is a result of the way the pregnant therapist relates to them, especially when anxiety and guilt have been mobilized in the therapist who is pregnant.

It is surprising that even though years had elapsed between the interview and the time when the women had been pregnant while in training, some of them did not spontaneously see or suggest that *they* might have contributed to the problem and that it was not just the patient's dynamics or a peer group and staff problem. As indicated earlier, the most insightful evaluations came from those who had been analyzed and had experienced a number of pregnancies, which resulted in increased self-awareness and understanding. Particularly interesting data came from those who had been in analytic supervision while pregnant and who could contrast this with their previous experience of being pregnant while a resident. These women had a greater recognition of their own needs and their families' needs, even as they recognized and could deal with the impact of their pregnancy on the patients. Supervision, therefore, became a rich and rewarding experience for supervisee and supervisor.

PRELIMINARY IMPRESSIONS

1. Pregnancy during the first year of residency tended to mobilize more defensive reactions on the part of the pregnant resident then it did in later years of residency training. In addition to individual defensive patterns, there was a general tendency to deny the impact of the pregnancy on the patient, staff, and the learning experience. Furthermore, there was a tendency to wish for more acceptance and understanding, even as the resident adopted a "business as usual" attitude. There was a tendency toward denial and externalization of the situation, to varying degrees.
2. The residents tended to mute the pleasure and joy of being pregnant, although when they were in an undemanding and supportive situation, they responded positively to it. Conflicts between professional identity and that of wife and mother have not been adequately examined but seem to be significant.
3. The middle phase of pregnancy was the most comfortable one, with the beginning perception of life and the beginning of a relationship with the life within, which seemed to consolidate the reality of the situation. By this time others had also made their adjustment to the pregnant therapist.
4. Late pregnancy was the most difficult period, with fatigue, mobilization of fears concerning delivery, a gradual withdrawal of libido from patients and work, and conflict about professional identity, which must have mobilized guilt and anxiety. Potentially, this was a period for rewarding work and self-understanding in work with patients. The analytic students seemed to do best in this area.

TENTATIVE RECOMMENDATIONS

As a result of these pilot interviews and data, it appears clear that the important area of pregnancy and the professional life of a woman contains many dynamics worthy of study, particularly as it concerns training, patients, and the complex interchange among staff, peers, and patients. We are planning a broader study that will include those who are in and have been in analytic training, since they can offer in-depth data and have a better grasp of their own contribution to the total interaction, as demonstrated in the pilot study.

1. A residency program not only has to be flexible in

such areas as scheduling for women who become pregnant, but it should also have someone (other than the supervisor and administrator) to whom the pregnant therapist can turn as friend, adviser, and ombudsman. In addition, the director of training can encourage the resident group and staff to work together and support the person involved.

2. In the initial interviews of women applicants, experience can be shared regarding the stress of the first year and a recommendation be made that pregnancy be planned, if possible, for sometime after the first year, which is the most stressful. It is interesting that thus far all of those interviewed had been trying to get pregnant and denied unplanned or unwanted pregnancy.

3. Women should also be aware of the lack of sophistication of men, including professional men, regarding the needs of pregnant women, the competitiveness of residents, sharing of responsibility, and feelings about pregnancy. Perhaps a process group could help work these things out so that pregnant therapists do not have to turn to patients for support and can be made to see that acting out on the part of the therapist does not encourage greater acceptance by the staff.

4. Supervisors of the pregnant resident could get together and share ideas on how to help the resident make use of the reality of her pregnancy in order to improve her work with patients and reveal and face their fantasies and feelings about how their needs are being met.

5. It is a truism that those involved in insight psychotherapy often have their own latent conflicts mobilized and can benefit from psychotherapy. The pregnant therapist can help by recognizing this and seeking help when she sees certain signs that she may be contributing to a problem in the therapeutic relationship. If the pregnant therapist has been "showing" for some time and most, if not all, of her patients avoid dealing with this fact, then the therapist is doing something that discourages the patients' dealing with it. If the therapist is leaning on the patients for support, this too should be examined.

6. Looking back on our program, which was a fairly structured one (as many medical-school-based programs are), we believe that everyone contributed to the problems that arose—administrative staff, supervisors, fellow residents, and the pregnant therapists. In the assessment of the total situation and of what is best for the program, the resident, and the staff, we must not lose sight of what is best for the patient.

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A Comparative Study of Predictive Criteria in the Predisposition of Homicidal Adolescents

BY ISMAIL B. SENDI, M.D., AND PAUL G. BLOMGREN, M.S.W.

The authors evaluated the criteria that are cited in the literature as predictive of homicidal predisposition. They applied three categories of criteria—clinical, developmental, and environmental factors—to a study group of 10 adolescents who had committed homicide, 10 who had threatened or attempted homicide, and 10 hospitalized controls. Their findings did not support the presence of a well-crystallized predisposition for homicidal behavior in this population, but they did show that the adolescents who committed homicide were psychotic-regressive and those who threatened or attempted homicide were organic-impulsive. The study strongly suggests the importance of environmental factors in reinforcing homicidal behavior.

THOSE WHO HAVE ATTEMPTED to describe the psychodynamic factors involved in the crime of murder seem to have different points of view. Some think that any individual who submits himself to the overpowering emotion of anger to the extent of committing murder transgresses not only ego control but also the controls and strictures of reality. Others imply that committing murder could mean a transient and temporary psychotic reaction. Psychiatry's position in this matter remains vulnerable and somewhat more insecure than that of the law when we focus only on "the immaturity of ego and the fuzzing of the boundaries of reality" (1).

For a long time the law has divided murderers into two groups, sane murderers with a motive and insane murderers without a motive. Juvenile murderers are either remanded to an adult court and subsequently referred to reform school or committed to a psychiatric institution as mentally ill.

Smith (1), who studied the cases of eight adolescent murderers, was tormented by the dichotomy of sane versus insane as defined by what he termed "an archaic legal rubric," the M'Naghten rule, which requires the knowledge of right and wrong as a test of sanity. On the basis of a dynamic exploration, Smith concluded,

> Characteristically these patients suffer early experiences of deprivation which result in an underdeveloped ego and a vulnerability to outbursts of violent aggression. (1)

This kind of psychodynamic interpretation (disregarding other clinical information) is sometimes considered an escape; the variety of psychiatric opinions on this subject may create a clash of experts. However, Salzman (2), in his report of a case of murder, stated that "the dynamic picture of the illness avoided the clash of the experts and served both the prisoner, the community and the psychiatric profession."

Guttmacher (3) indicated that the greatest number of murderers do not represent any particular psychopathology. This opinion has been challenged, especially in the cases of homicidal adolescents. Bender (4) reported objective clinical criteria among 33 children who had killed. These included age, sex, nature of killing, clinical diagnosis, IQ, EEG abnormality, compulsive fire setting, and extremely unfavorable home conditions.

MacDonald (5), Satten and associates (6), and others (7–10) reported different criteria in the histories of those who atempted to kill and of those who killed without a motive. Satten and associates reported the presence of episodic dyscontrol in some murderers; these subjects episodically exhibited alterations in their state of consciousness as well as violence and bizarre behavior. Satten and associates also discussed the victims who coincidentally fit into the unconscious conflicts of the murderers.

Bender (4), Easson and Steinhilber (10), and others (1, 2, 7, 11, 12) described a stereotype of the homicidal adolescent as an unwanted child with an underdeveloped ego that resulted from oral and maternal deprivation. A vulnerability to outbursts of violent aggression was also described as part of this stereotype. In the presence of a weak and distant father, an aggressive, destructive mother encourages a symbiotic attachment. In some cases the presence of a schizoid personality or dynamically schizophrenic pathology was reported. Homicidal impulses have sometimes been directed toward family members simply as a move against intolerable anxiety.

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The authors wish to dedicate this study to the late Peter G.S. Beckett, M.D., who made it possible.

OBJECTIVES OF THE STUDY

We searched the reports of various authors (1–13) to identify clinical, diagnostic, and prognostic features of murderers. Since these features were reported in clinical and narrative form for different cases of murderers, most of whom were adults, we clustered them into the three following categories: 1) predictive criteria that coincide with factual clinical information, 2) predictive criteria that study the personality or environmental factors interfering with development, and 3) predictive criteria that include psychodynamic or environmental factors reinforcing the child's vulnerability to outbursts of violent aggression.

METHOD

A specific statistical and evaluative form was prepared for this study to include all of the criteria suggested in the literature. We used this form to accumulate the available information for comparative study.

Ten adolescent patients accused of committing murder were admitted to the Child Psychiatry Division of Clinton Valley Center during a recent six-year period. (For the purposes of this study, these adolescents will be referred to as those who committed murder.) The case histories of 10 youngsters who unsuccessfully attempted homicide or threatened to commit murder were also available. These 20 subjects were all adolescent boys; they were studied as two separate groups.

Another group of 10 adolescents was randomly selected from among hospitalized patients as control subjects. These youngsters had been hospitalized for such psychiatric problems as schizophrenia, personality disorder, organic brain syndrome, and learning disability compounded by emotional and behavior disorders.

The complete record of each boy as well as his current behavior were studied by two independent raters for one week; each rater then scored the statistical evaluation form. The presence or absence of each criterion was scored independently. These data were later cross-validated.

Four raters (three child psychiatrists and one social worker) participated in the scoring and evaluation of the case histories and current behavior. The agreement among raters for scored criteria was almost at the 95 percent level. The distribution of the three categories of the scored criteria among the three groups of adolescents was obtained, and the chi-square test was applied to identify the clusters of significant criteria among the three groups.

RESULTS

Clinical Factors

Table 1 shows the incidence of clinical findings among the three groups of adolescents. The mean ages for the three groups were 14.6 years for adolescents who committed homicide, 14.5 years for the group who threatened or attempted homicide, and 15.1 years for the control group. A majority of the adolescent murderers were diagnosed as schizophrenic, and 70 percent of the group who threatened or attempted homicide were identified as having organic brain syndrome. Three boys in the latter group were schizophrenic, and 4 boys in the former group were suffering from personality disorder. Eight of the boys in the group who committed homicide had an average or above-average IQ, and 60 percent of the adolescents who threatened or attempted homicide showed a retarded or below-average IQ. Academic deficiency appeared to be very prominent among the adolescents who threatened or attempted to kill (9 boys); 5 of the boys who committed homicide were academically retarded by two years or more.

The three factors of fire setting, enuresis, and cruelty to animals were equally distributed among the three groups. This triad was distributed insignificantly among the group who committed homicide and was not significantly distributed in this group in comparison with the other two groups. The triad was not present in a global form in any patient; generally, each patient had only one or two of the signs.

EEG abnormality was more prevalent among those who threatened or attempted homicide; only 20 percent of those who committed homicide exhibited abnormal EEGs.

Nature of the Crime

Ninety percent of the homicides were intentional. One murder happened accidentally as a result of setting a fire. In 6 cases, the murder was committed by shooting, in 2 by strangulation, choking, or kicking, and in 1 case, by stabbing the victim to death.

All of the homicide threats and attempts were intentional. No firearms were used in any of these attempts. In 5 cases, the assaults took place by stabbing; the other 5 boys attempted to strangle or choke their victims.

Four adolescent murderers chose their victims from among family members; 6 boys killed either friends or strangers. In 4 of the cases the victims were selected, and in 6 cases the victims were coincidental, fitting into unconscious conflicts of the murderers.

Among the adolescents who attempted or threatened to kill, 3 of the boys attacked family members and 7 attempted to assault friends or strangers.

Personality and Developmental Factors

Since only 9 out of 20 criteria in the category of personality and developmental factors were found to be significantly present in our study population, we compared and analyzed the distribution of these factors among the three groups. Table 2 lists these factors and their incidence among the three groups.

A significant percentage of both the group who committed homicide and the group who attempted or threatened homicide came from an extremely unfavorable home environment in comparison with the control group. An unfavorable home environment was defined as one in

TABLE 1
Incidence of Clinical Factors Among Three Groups of Adolescent Boys

Factor	Adolescents Who Committed Homicide (N = 10)	Adolescents Who Threatened or Attempted Homicide (N = 10)	Control Group (N = 10)
Diagnosis of schizophrenia	6	3	4
Diagnosis of organic brain syndrome	0	7	3
Diagnosis of personality disorder	4	0	3
Below-average or retarded IQ	2	6	4
Academic deficiency of two years or more	5	9	5
History of compulsive fire setting	3	2	3
History of cruelty to animals	2	3	3
History of enuresis	3	3	2
Abnormal EEG	2	6	4

TABLE 2
Incidence of Personality or Developmental Factors Among Three Groups of Adolescent Boys

Factor	Adolescents Who Committed Homicide (N = 10)		Adolescents Who Threatened or Attempted Homicide (N = 10)		Control Group (N = 10)
	N	Significance*	N	Significance*	
Unfavorable home environment	8	p<.05	8	p<.05	4
Parental brutality	6	p<.01	3	n.s.	1
Exposure to violence or murder	5	p<.05	0	n.s.	0
Parental rejection and deprivation	5	n.s.	7	n.s.	4
Sexual inhibition	5	p<.10	2	n.s.	2
Seduction by parent or perversion in parent	4	p<.025	1	n.s.	0
Speech disturbance or stuttering	3	n.s.	4	n.s.	2
Episodic dyscontrol	2	n.s.	7	p<.005	1
Suicide attempts	1	n.s.	3	n.s.	1

*Represents comparison with control group by chi-square analysis.

which a considerable amount of stress was present, including parental neglect, abuse, or absence.

In comparison with the control group, a statistically significant proportion of the adolescents who committed murder were exposed to parental brutality and to violence or murder in their immediate home environment. It also appears that the adolescents who killed had a significantly higher exposure to the destructive factor of seduction by a parent or perversion in a parent than either the control group or the group who attempted or threatened homicide. The boys in the group who had killed were also seriously troubled in their sexual development—they showed a higher distribution of sexual inhibition and sexual immaturity than either of the other groups.

The presence of parental rejection and deprivation did not differentiate the three groups, despite the high incidence of this factor among all three. The presence of speech disturbance or stuttering or of suicide attempts was not significant.

In brief, the significant presence of five factors in this category—unfavorable home, parental brutality, exposure to violence or murder, seduction by a parent, and sexual inhibition—distinguished the adolescent murderers from the group who attempted or threatened to kill and the control group. Only two factors in this category, unfavorable home environment and episodic dyscontrol, separated those who attempted or threatened to kill from the control group and the group of adolescents who killed.

Environmental-Psychodynamic Factors

Table 3 shows the incidence of environmental factors influencing psychodynamics among the groups. Adolescents who committed homicide were differentiated from the control group by six different factors in this category. Included among these were the following: long history of schizoid adjustment, maternal symbiosis, availability of firearms in the home, and victim was coincidental. Two less significant factors also identified this group—brutal rejection by father and murder or violence encouraged by family. With the exception of the latter two factors, these criteria also differentiated adolescents who committed homicide from those who threatened or attempted to kill.

Unlike the adolescents who committed murder (who

TABLE 3
Incidence of Environmental Factors Influencing the Pschodynamics of Three Groups of Adolescent Boys

Factor	Adolescents Who Committed Homicide (N = 10)		Adolescents Who Threatened or Attempted Homicide (N = 10)		Control Group (N = 10)
	N	Significance*	N	Significance*	
Long history of schizoid adjustment	7	p<.005	2	n.s.	1
Maternal symbiosis	6	p<.05	4	n.s.	2
Brutal rejection by father	5	p<.10	7	p<.025	2
Availability of firearms in the home	5	p<.05	0	n.s.	1
Distant and passive father	4	n.s.	7	p<.05	3
Early deprivation	5	n.s.	6	n.s.	4
Murder or violence anticipated by family	3	n.s.	5	p<.05	1
Murder or violence encouraged by family	2	p<.10	4	p<.005	0
Having been an unwanted child	2	n.s.	6	p<.05	2
Victim was coincidental	6	p<.025	0	n.s.	0

*Represents comparison with control group by chi-square analysis.

exhibited chronic schizoid adjustment and intense maternal symbiosis), the group who attempted or threatened homicide was differentiated from the control group and the group who killed by five factors in this category: having been an unwanted child, brutal rejection by father, distant and passive father, murder or violence anticipated by family, and murder or violence encouraged by family.

DISCUSSION

Many of the factors studied in the work described here have been cited by different authors as being influential in the behavior of homicidal patients. These factors had been scattered in the reports of different authors (for mostly adult populations). A systematic statistical application of the factors cited has been considered in three categories: clinical, developmental and personality, and environmental-psychodynamic. Applying the three categories of factors, the predispositions of the young murderers studied here were distinguished in different areas from the group who threatened or attempted homicide and other hospitalized patients.

On the clinical level, more of the young murderers in this study were schizophrenic, more had average or above-average intelligence potential, and half fulfilled their academic potential. EEG abnormalities were not prominent in this group, and the triad of fire setting, enuresis, and cruelty to animals was not significantly present. The group of boys who committed murder could not be differentiated from control patients or from those who threatened or attempted to kill by the presence of this triad. In comparison, the group who threatened or attempted to kill showed a high degree of EEG abnormality and organic brain syndrome; the majority had a low or retarded IQ and were markedly deficient in their academic achievement.

The clinical factors examined in this study classified the two homicidal groups as follows: the organic-impulsive group were those who threatened or attempted homicide, and the psychotic-regressive group were those who actually committed homicide.

The organic-impulsive group revealed a basic deficiency in their predisposition that reflected a long-standing organic condition resulting in intellectual limitation, academic stagnation, and setbacks in their social and family roles. However, no one would claim that any youngster showing this kind of deficiency is predisposed to homicidal impulses.

The organic-impulsive group was also affected by another deficiency in their personality functioning in the form of episodic dyscontrol or episodic release of primitive and explosive aggression. Furthermore, the group of patients who threatened or attempted homicide were seriously affected by long-standing and immediate environmental factors affecting their personality functioning and the dynamics of their interpersonal relationships. Most of the organic-impulsive group had been brought up in an unfavorable home environment (8 boys) and were unwanted children (6 boys). On the immediate level, the organic-impulsive group was exposed to brutal rejection by a father who was distant and passive (7 boys). In such a home environment the already handicapped child was confronted with the anticipation of an act of murder or violence; the act of murder or violence was encouraged in many cases.

What distinguished the organic-impulsive group from adolescents who actually committed homicide (the psychotic-regressive group) in this study appeared to be the nature of their basic deficiency and the intensity and prevalence of different environmental factors.

Unlike the organic-impulsive group, the psychotic-regressive group had a basic deficiency closely interwoven with widespread and significant environmental factors. Hypothetically, for the psychotic-regressive group the personality characteristics present before the onset of psychosis or the act of murder could be considered the child's predisposition; the nature of this predisposition

was found to be prepsychotic or psychotic. The majority of the adolescents who had committed murder had a chronic schizoid adjustment and an intensive symbiotic relationship with their mothers. They had exhibited marked sexual inhibition and sexual immaturity.

It is obviously impractical to assume that these characteristics in themselves would constitute homicidal potential. However, the long-standing environmental assaults that appeared influential in reinforcing the act of murder seemed instrumental in the development of a prepsychotic condition in the adolescents who committed murder.

The environmental assaults were identified as parental brutality, exposure to violence or murder among family members, seduction by a parent or perversion in a parent with sadistic behavior, and brutal rejection by the father. These youngsters also came from unfavorable home environments where maternal symbiosis was further reinforced by the factor of the father's brutality and rejection. The more immediate environmental factors were found to be the availability of firearms in the home and the presence of a victim who reactivated unconscious conflicts. It would also appear that violence or murder was encouraged by one of the parents in the homes of adolescent murderers.

CONCLUSIONS

In the final analysis, this study does not support the presence of a well-crystallized predisposition for committing, threatening, or attempting homicide. Basically, the predisposition for committing homicide was found to be psychotic-regressive, and the predisposition for threatening or attempting homicide was found to be organic-impulsive. This study strongly suggests the importance of environmental factors in reinforcing homicidal behavior.

Environmental factors were instrumental in generating the impulse to murder in the psychotic-regressive group and the impulse to threaten or attempt murder in the organic-impulsive group. Eight different environmental factors were identified for adolescents who committed murder, and six factors were found significant in reinforcing homicidal threats or attempts (see appendix 1).

The intense and widespread hostile-destructive nature of the environment of adolescents who committed homicide appears more detrimental to their premurder disposition than the less intense but hostile-rejecting environment of adolescents who threatened or attempted homicide.

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APPENDIX 1

Predispositional and Environmental Factors Present in the Histories of 20 Adolescents Who Committed, Attempted, or Threatened Homicide

PREDISPOSITIONAL FACTORS FOR PSYCHOTIC-REGRESSIVE GROUP (THOSE WHO COMMITTED HOMICIDE, N = 10)

1. Long history of schizoid adjustment
2. Maternal symbiosis
3. Sexual inhibition
4. Average or above-average IQ
5. Normal EEG

ENVIRONMENTAL FACTORS FOR PSYCHOTIC-REGRESSIVE GROUP

1. Unfavorable home environment
2. Parental brutality
3. Exposure to violence
4. Seduction by parent or perversion in parent
5. Brutal rejection by father
6. Victim was coincidental
7. Availability of firearms in the home
8. Murder or violence encouraged by family

PREDISPOSITIONAL FACTORS FOR ORGANIC-IMPULSIVE GROUP (THOSE WHO ATTEMPTED OR THREATENED HOMICIDE, N = 10)

1. Organic brain syndrome or minimal brain damage
2. Abnormal EEG
3. Intellectual retardation
4. Academic deficiency
5. Episodic dyscontrol

ENVIRONMENTAL FACTORS FOR ORGANIC-IMPULSIVE GROUP

1. Unfavorable home environment
2. Having been an unwanted child
3. Brutal rejection by father
4. Distant and passive father
5. Murder or violence anticipated by family
6. Murder or violence encouraged by family

Psychological Dimensions of Internation Dependency

BY STEVE R. PIECZENIK, M.D.

The author analyzes the psychological consequences of international dependency, advancing 13 propositions as clues for a heuristic understanding of the dynamics of dependent relationships between nations. He believes that these relationships must be understood before they can be improved. The author proposes coequal alliances and multinational aid as desirable alternatives to existing political-economic-military strategies.

AS THE REALITY of global interdependence grows more apparent, it becomes imperative to clarify the psychological aspects of the dependency phenomenon. Formulations of the nature of dependent relationships, whether individual or national, have never fully attained the sanction of scholarly research. The psychological and political science literatures reflect different traditions of thought that range from pathological to cybernetic models. Each, however, subsumes the importance of dependency under a different, more salient category.

For the Freudian analysts, dependency is significant only as it is defined in pathological states (e.g., depression) or as part of the normal psychosexual developmental process. One senses that "dependency" in terms of oral dependency or deprivation connotes a feeling of vulnerability wherein the child lacks any clear behavioral options other than being nurtured or being deprived (1). The concepts of mutuality, exchange, and reciprocity are absent.

The Kleinian analysts also emphasize the importance of preoedipal dependency as a crucial factor in the formation of the defense mechanisms of introjection and projection, as well as the personality formation of paranoid, schizoid, and depressive disorders (2).

The formal values, attitudes, and expectations of a dependent relationship are more clearly explored in the literature on role theory in social psychology. The language of dependency is transmuted into "matrices of possible interactions and outcomes," with the dynamics of the relationship explained as "an interference and facilitation in interaction" (3). Consistent with this line of reasoning are the theories of international relations that discuss dependency or interdependency as functions of economic-political-military coalitions and alliances, usually operating on the principle of nonzero-sum games (4).

The group theory literature offers some interesting insights into the nature of international bargaining and coalition formation, but it does not discuss the possible dependency problems that might arise in the formation of these coalitions (5).

For the most part, the psychiatric, social psychology, and international theory literatures can be dovetailed into a body of knowledge that ostensibly recognizes the phenomenon of dependency but that, because of omission or restraint, does not analyze the psychological dynamics or consequences of dependent or interdependent relationships. An exception to this generalization is the body of literature related to the discriminatory problems of inequality that arise from imperialism or from sexual differences. The literature on colonial oppression is polemical in style and normative in substance (6), with a basically Marxist orientation that is combined with a tone of moral indignation. These writers do, however, emphasize the detrimental psychological consequences (e.g., low self-esteem, distorted self-image, increased frustration, and alienation) of a political-social dependency.

From this body of literature, particularly the works on sexual inequality (7), one can glean several propositions about the dynamic characteristics of the dominant and subordinate members in the dependent relationship.

One necessary caveat should be inserted at this point. In order to deal effectively with the abstract notion of collective national behavior, political scientists have hypothesized constellations of attitudes and emotional concerns to characterize a particular nation or political culture. In designing their foreign policy vis-à-vis another country, governments frequently commit themselves to certain images or belief systems they consider characteristic of a political system or regime (5). To say that a nation is dependent does not imply that all of its citizens share the same views or sentiments; rather, a state of dependency is perceived by foreign policy decision makers and acted upon accordingly.

INTERPERSONAL PROPOSITIONS WITH FOREIGN POLICY ILLUSTRATIONS

One may accept the notion that the key feature of a dependent relationship is its asymmetry in the perception of at least one of the involved parties. In part, perception of the asymmetry involves the notion that one

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of the members is, in fact or in fantasy, the dominant one (as defined by power, status, prestige, and/or resources) and the other is subordinate. This inequality characteristically generates affects (e.g., anger, envy, and jealousy) and irrational attitudes that spiral into a counterproductive relationship of unfulfilled needs and unrealistic demands. In interpersonal relationships, this type of situation occasionally leads to overt conflict, but it is more often played out in a continuing covert conflict entailing hostile dependency and sadomasochism, sometimes ending in mutual self-destruction.

The following propositions, which are derived from the behavioral literature, are advanced in an attempt to characterize the nature of the inequality of a dependent relationship and the psychological consequences of that inequality. The propositions are a heuristic tool to expand our understanding of international dependency.

DOMINANT MEMBER PROPOSITIONS

Proposition 1

In a dyadic relationship, the dominant member often provides the subordinate member with an acceptable role for self-definition. This designated role incorporates those aspects of the relationship that are considered inferior in value and prestige. Psychologically, it fosters submissiveness coupled with guilt, self-anger, and rage. A prime example of this can be seen in the American foreign aid program, which designates many recipients as "underdeveloped" or as "LDCs" (lesser developed countries). These countries express their gratitude in the now classic graffiti, "Yankee, go home!"

Proposition 2

The dominant member disguises the true nature of the inequality in the relationship by rationalizing the differences as a fait accompli and by insinuating himself as the desirable role model. Initial subordinate acquiescence is coupled with developing mistrust, resentment, and envy. Feelings of frustration and despair follow the realization that one's growth has been impaired. From the Wilsonian "crusades" to the Nixon doctrine, the United States has offered itself (at times unwittingly) as the exemplar of nation-state behavior, continually reaffirming its moral and ideological rectitude and technological superiority. In turn, our Western allies appear mistrustful, wary of what role, if any, they will play in the major balance of power. U.S. initiatives to implement détente and the recent successful mediation efforts during the Yom Kippur War have been followed by cries of outrage, contempt, and abandonment from Western European nations.

Proposition 3

The dominant member maintains the asymmetric relationship in order to foster the dependency of the subordinate and to reaffirm feelings of self-worth and self-importance. In turn, the subordinate member suppresses his accumulated resentment in order to avoid a futile confrontation. U.S. relations with the Latin American countries are described in these terms in the so-called *dependencia* literature in which any U.S. assistance or aid, no matter how well intended, is viewed as a political-economic stratagem specifically designed to reinforce the dependent relationship. This accrued resentment was apparent in the revolutionary rhetoric in Allende's Chile and Perón's Argentina.

Proposition 4

The dominant member uses idealization and praise to subtly devalue the subordinate member. By praising features that the subordinate member considers worthless and ineffective, the dominant member deprecates those aspects of the subordinate that could lead to an equalization of the relationship. Recent U.S. paeans to the newly discovered Arab culture and friendship avoid any mention of such attributes as initiative, industry, temperance, and self-reliance in these "favored recipients" for advanced U.S. technological assistance.

Proposition 5

The dominant member determines both the emotional and behavioral tones of the dependent relationship, intruding its political culture (including its ethos, morality, and social theory) in order to legitimize the relationship by allowing the subordinate member to incorporate aspects of its own culture. Clear evidence of this pattern is the pandemic fear abroad of losing one's culture to the impending peril of "Americanization."

Proposition 6

Consciously or unconsciously, the dominant member orchestrates a scenario of covert conflict. The claim of common interest is invoked as the rationale to avoid cause for conflict. In the process, one observes a tightening of constraints in an already established dependent relationship that appears too lax. In the international arena, the South Vietnamese and the Thais were designated U.S. allies during the Viet Nam war to share in the burden of fighting. Maintaining that dependent friendship was both costly and emotionally taxing, as has been evidenced by subsequent internal disruptions that have often been directed against the United States. These included student revolts, which in one case overthrew the government.

SUBORDINATE MEMBER PROPOSITIONS

Proposition 7

The subordinate member is primarily concerned with his psychological, cultural, and physical survival. Accordingly, direct and honest reactions to the constraints or the destructive treatment by the dominant member are scrupulously avoided. Self-interested direct action is muted, if not totally suppressed. An example of political self-destruction was the recent resignation of the Greek military junta after it had defied the seven-year constraints of the U.S. and NATO dependency relationship by masterminding the Greek Cypriot coup.

Proposition 8

The subordinate member, unable to assert himself openly, must resort to deception and manipulation as primary modes of behavior. This behavior often assumes the skillful guise of good humor or egregious self-deprecation, intended ultimately to devalue the dominant member. DeGaulle, for example, was accomplished in the art of appearing agreeable while manipulating the inherent weaknesses of the superpowers (often playing them off against each other).

Proposition 9

Through the defense mechanism of identification with the aggressor, the subordinate member may appear more dominant than the actual dominant member. In order to minimize feelings of inadequacy, impotence, and rage, the subordinate member incorporates and identifies with the values of the dominant member that appear repressive. In situations where the roles become reversed, i.e., the subordinate member becomes the dominant member, those initial repressive attributes hypertrophy and are displaced onto the newly subordinated member (7).

In the field of international industrialization and economics, the Japanese have out-Americanized the Americans—unfortunately, at great psychological expense to the Japanese culture. This expense can be seen in the reactive resurgence of episodes of Samurai militarism. The Japanese have also reversed their role from subordinate to dominant in their relationships with Taiwan, the Philippines, and Southeast Asia, where they are seen as economically oppressive imperialists.

Proposition 10

The subordinate member is more cognizant than the dominant member of the true nature of their relationship because he understands that its underlying weakness lies in the dominant member's basic inability—no matter how valiant the effort—to satisfy the subordinate's demands. The subordinate member uses this insight to further weaken the dominant member by covertly spiraling demands and expectations that the dominant member is unable to meet. Both members engage in an escalation of mutual hostility, resentment, and guilt. The United States, despite its magnanimous foreign aid gestures, is continuously made to feel inadequate (not enough or not the right kind of aid). In fact, this country appears helpless to control the fractious behavior of the recipients of its aid. It would not be an exaggeration to cast the United States in the role of the "helpless giant" who can never do right in its relationships with countries such as India.

Proposition 11

The subordinate member is often unaware of feelings of envy and jealousy toward the dominant member. These feelings are created by the asymmetry of power, prestige, and possession. If left unresolved, the feelings fuel the covert conflict into a prolonged hostile-dependent relationship marked by impatience, compulsive competition, greed, guilt, increasing demands, and unfulfilled needs with, however, no overt presentation of anger or resentment. Instead, the dominant member is praised in order to ward off fear of retaliation and feelings of guilt.

Such a phenomenon is especially true of Western allies who resent their military-economic dependency on the United States. While reaffirming their faith in NATO, a few prominent allies scurry about the world making technological and economic deals in quiet defiance of the United States. However, if the United States does not consult its allies, they become petulant, acting as if their integrity has been seriously injured and their economies drastically deprived.

Proposition 12

The subordinate member tends to move toward open conflict by recognizing the inequality and questioning the underlying basic assumption of the dependent relationship (7). The dominant member behaves in the opposite fashion, attempting to maintain the status quo and to obviate any overt expression of discontent and hostility. Portugal's relationship with her African colonies involved an initial period of quiescence marked by the submission of the subordinate colonies, followed by a period of covert (guerrilla) conflict aimed at politicizing the existing inequality. This finally terminated in open conflict that led to eventual nation-state independence.

Proposition 13

Both the dominant and subordinate members in a dependent relationship avoid conflicts of interest, attempting instead to destroy each other psychologically. Each, in turn, subjugates the other through self-serving techniques. The subordinate member denies the dominant one the feedback that is necessary to validate the latter's actions and reality. The dominant member must then persist in his self-initiated social reality without the advantage of validation from the dependent member. What saves the dominant member from a totally delusional system in the international arena are the realistic political and economic demands for a viable national posture and international strategy.

The dominant member deprives the subordinate member of psychological integrity and self-esteem through the creation of a dependent donor-client relationship and the subsequent assignment of secondary status.

DISCUSSION

In the true sense of Hegelian dialectic, each member in a dependency relationship is dependent on the other and is subjugated to the unequal demands, needs, and tactics of the other. The resolution is not, as Hegel would insist, a synthesis of this inequality, but rather a total redefinition and eventual realignment of the asymmetry. In an unequal relationship, the oppressed may become the oppressor and vice versa. This is the true paradox and tragedy of inequality.

Fortunately, we are not limited to either the cynicism of human or nation-state frailty or to the despair of inevi-

table failure. Inherent in the distortion of inequality is the possible clarity of equality. To arrive at equality one must first recognize that the dependency relationship is ipso facto unequal and that this inequality retains certain irrational characteristics (as well as rational ones) on the part of both members which spiral a covert conflict. This conflict is marked by disguised anger, hostility, ambivalence, jealousy, and envy, as well as by admiration and positive affect.

Once recognized, dependency relationships may be minimized by preempting the need to develop a dependent relationship through multinational aid and coequal alliances, thereby obviating the designation of the subordinate as dependent, underdeveloped, or in need. Other alternatives include self-directed programs designed to promote autonomy (e.g., U.S. Project Independence for 1980 during the energy crisis). An alternative strategy for the major powers in their relationships with the third world might include "benign neglect" or disengagement (especially military withdrawal), allowing those countries an opportunity for self-definition and psychological autonomy. Still another strategy would be to increase mutual dependency. For example, the strategy of the United States vis-à-vis Russia and the People's Republic of China could be based on the psychological premise that increasing mutual interests diminishes the possibility of both covert and overt conflict.

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EDITORIAL

Identifying Trends in Residency Training: A Basis for Improving the Profession

BECAUSE THE FUTURE of the profession of psychiatry depends in great part upon how its young are prepared, the lead article in this issue will be read with interest by many of our colleagues, particularly those engaged in professional education.

Dr. Lee Gurel, Director of the Division of Manpower, Research and Development of the American Psychiatric Association, has abstracted this paper from its parent monograph (prepared by him and his associates) entitled *A Survey of Academic Resources in Psychiatric Residency Training*. The purpose of the study was to obtain quantitative descriptive data about psychiatric residency training programs. The study was conducted under provisions of an APA–National Institute of Mental Health contract at a time (1972) when the author believed psychiatric practice and education were being subjected to considerable criticism, hence his attempt to obtain "hard" data about the scope and nature of graduate psychiatric teaching programs that might become useful in understanding current trends.

One will find tabulations and commentary relating to resident staff, psychiatric and other professional faculty, experience with selected patient types and conditions, range of therapeutic intervention, and participation in related training programs. These data emerge from responses to a questionnaire used by the Residency Review Committee for Psychiatry and Neurology to obtain information through its periodic three-year examination of training programs approved by its parent bodies, the American Board of Psychiatry and Neurology and the Council on Medical Education of the American Medical Association. As the questionnaire used is the same, some (but not all) of this information is available in the annual educational number of the *Journal of the American Medical Association*. Thus, many of the results cited in this paper and in the monograph are familiar to those of us who have directed programs. For example, one will find that one-half of the programs are located in the northeast, that there is a limited number of residents at fourth- and fifth-year levels, that over one-quarter of all residents were graduates of foreign medical schools and that they are principally enrolled in nonmedical school settings, that there is a considerable number of psychiatrists engaged part time in the training of residents, that there has been a substantial increase in the number of psychologists and other nonmedical professionals engaged in teaching residents, and that there appears to be homogeneity among the programs in the repertory of psychopathology of patients studied and cared for and in the range of therapeutic intervention.

While the descriptive tabular data serve a useful purpose as a baseline for comparison, the narrative responses of the program directors to several issues posed to them may be of greater interest. These were responses to questions that reflect the particular interest of the NIMH staff, cosponsor of the study. In great part they were concerned with matters relating to the delivery of health services, with particular attention to child mental health, minority groups, interdisciplinary collaboration, community organization, etc.

The limited number of responses and the wide diversity in content of those who responded are evidences of present-day confusion, if not controversy, as to the appropri-

ate role of the practicing psychiatrist. This is quite understandable as there are at the moment no clear-cut definitions of the public health, social, and political roles, just as there are no clear descriptions of the roles of both nonmedical professional and paraprofessional persons who are engaged in interdisciplinary involvements with psychiatrist physicians.

In a sense, these questions and their responses represent a vanguard movement of what will be taking place in all of medicine. They reflect our increasing concern with the delivery of health services, with the awareness of our current deficiencies in the continuity of care of our patients, and with the search to learn what are the measures—including how to increase the pool of colleagues, both professional and paraprofessional—to best serve our patients' needs.

One would hope that these objectives could be achieved without risk to the promotion and sustained support of scholarship and inquiry. Regrettably, there is an anti-intellectual movement promoting craftsmanship at the cost of scholarship through truncating the undergraduate medical curriculum and eliminating the internship. There is also a false egalitarianism obscuring and denying the differences in education, knowledge, skill, and responsibility between professionals and paraprofessionals in the interdisciplinary care of patients.

These trends must be identified and corrected if the psychiatrist is to fulfill his major and unique function of serving as a crucial bridge between genetics, biology, and clinical medicine on the one hand and the behavioral sciences on the other. To neglect scholarship and experience at either pole would be to diminish his usefulness for tomorrow.

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Twins in a Child Psychiatry Clinic

BY MARIA PALUSZNY, M.D., AND A. GEOFFREY ABELSON, M.ED.

The authors found that 22 of the 2,015 referrals to a children's psychiatric clinic during a six-year period were twins—half the number that would be expected on the basis of the national incidence of twins. Evidence of minimal brain dysfunction was found in a higher percentage of the twins than in a matched nontwin group. The authors suggest that factors often inherent in twins (e.g., prematurity and birth difficulties) may be related to this finding.

TO ASSESS THE TYPES of difficulties found in a population of twins seen in a child psychiatry clinic, we posed the following questions: Do twins show a greater frequency of psychiatric disturbance than nontwins? How often are both twins referred? Is there a "typical problem" for which twins are referred? How often is the twin relationship the reason for the referral? How similar are the evaluation findings for a twin population to those of a control group? In order to answer these questions, we reviewed records of all the twins seen in a children's psychiatric clinic over a six-year period and compared these children with a matched control group from the same clinic.

METHOD

Children's Psychiatric Hospital of the University of Michigan, Ann Arbor, Mich., is a training center for child psychiatry residents, medical students, and general psychiatry residents. All evaluations are conducted under the supervision of senior psychiatric staff, who rate historical and behavorial variables in addition to conducting traditional psychiatric evaluations. Psychological test results, a social history, and special studies (for example, an EEG or a neurological evaluation) are usually available for these children.

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Subjects

We reviewed the charts of children evaluated between 1966 and 1972 at the clinic, selecting for analysis the records of all twins. These records were then matched with those of a control group of nontwins on the variables of age, sex, race, and socioeconomic status. Social class was assessed by the Hollingshead (1) criteria; i.e., the father's formal education and occupation were rated on a scale of 1 to 5 (1 represents the highest social class and 5 the lowest). Factors that were considered part of the twin situation (birth difficulties, age of the mother, and prematurity indicated by birth weight), were not matched in the control group. We felt these problems were inherent in twins and therefore could not be separated out.

RESULTS

Demographic Data

Only 22 of the total of 2,015 children evaluated from 1966 to 1972 at the clinic were members of twin pairs. As there are 20 plural births per 1,000 live births in the United States (2), we would have expected twice this number. Of the 22 twins seen, 3 were identical and 19 were fraternal. In 12 cases, only 1 member of a twin pair was referred; the remaining 10 children represented 5 twin pairs. The age range of the sample was 4 to 13 years, with a mean of 7 years. There were more boys than girls (13 versus 9) and more white children than black children (16 versus 6). The average socioeconomic class of the group was 4, with a range of 2 to 5. (As we have mentioned, the control group was matched for age, sex, race, and socioeconomic status but not for prematurity.) Eleven twins were full-term (i.e., they had a birth weight over 5-1/2 pounds), 10 were premature, and the birth weight of 1 was unknown. In the control group, 19 children were full-term, 1 was premature, and birth weights of 2 were unknown.

Referral Information and Evaluation Findings

We found that the twins were referred for the following reasons: learning problems or developmental delays, N=12; behavioral problems (aggressive, impulsive, or hyperactive behavior), N=3; neurotic problems, N=2; psychosomatic difficulties, N=2; and court referrals (preadoption and neglect cases), N=3. The control group showed a slightly different distribution of referral problems: there were 8 behavioral problems, 6 cases of learning problems or developmental delays, 4 neurotic problems, 2 psychosomatic difficulties, and 2 court referrals (a litigation case concerning injuries and a custody case). The postevaluation diagnosis for the two groups showed a higher incidence of learning problems and developmental delays in the twin group and a higher incidence of psychoneurotic, psychosomatic, and behavioral problems in the control group.

Comparison of the evaluations for the two groups revealed an important difference—a high proportion of the twin group could be classified as showing minimal brain dysfunction (MBD). This term has been used to describe a variety of behavioral characteristics typical of hyperkinetic children, as well as "soft" neurological signs and psychological test results suggestive of organic damage (3). We used two criteria to indicate evidence of MBD. First, the children had to show at least two of the following signs during the evaluation or in the history: slow or uneven development, learning problems, coordination problems, hyperactivity, impulsivity, concentration problems (distractibility), or emotional lability. Second, we required more objective evidence of possible organic dysfunction as measured by psychological evaluation, neurological examination, or EEG. A majority of the children showed problems in psychological testing by having a wide range between verbal and performance IQ scores (with the verbal scores more than 20 points lower) and/or evidence of perceptual motor problems such as reversals, rotations, perseverations, difficulties with angulations, etc. Only children who satisfied both criteria were classified as showing MBD. The two exceptions were 1 twin and 1 child in the control group. Psychological testing was unavailable in these 2 cases, but the history, psychiatric evaluation, and final diagnosis all indicated MBD.

By this method, we found 15 children in the twin group who were classified as showing MBD. Of these, 11 showed no retardation and 4 showed retardation, as measured by the Wechsler Intelligence Scale for Children or the Stanford-Binet. (A child was considered retarded if the IQ was below 85 and the evaluator felt organic problems rather than emotional factors were responsible for the low score.) In the control group, 8 children showed MBD; 3 of them were retarded and 5 were not.

The statistical analysis was done in two steps because the retarded group was too small to consider as a separate cell (4). In the first analysis, the retarded children were included with the MBD children in both groups; in the second, they were excluded from the computations. The results for the first computation (which included retarded children) indicated a significantly higher frequency of MBD in the twin group than in the nontwin comparison group ($\chi^2=3.28$, $p<.05$, d.f.=1) as did the second analysis (in which retarded children were excluded) ($\chi^2=3.24$, $p<.05$, d.f.=1). We concluded that the major difference was in the number of children who showed minimal brain dysfunction and that the difference was not necessarily associated with retardation.

TWIN RELATIONSHIPS

In 2 sets of twins, the primary reason for referral was twin dependency. In one of these cases, the dependent twin (whom we will call John) was a retarded five-year-old boy who was afraid of Joan, his aggressive and domineering twin sister. John was described by the parents as "having no identity of his own." At times he called himself Joan and usually referred to himself as "she." It appeared that this handicapped boy was not just dependent on his sister but had used the defense of identification with the aggressor to a degree that interfered with normal self-identity development.

The other dependent pair, whom we will call Don and Ron, were four-year-old fraternal twins whose dependency was mutual. These children used twin language, played exclusively with each other, and would not even separate to go shopping with one of their parents. Although neither child was retarded, both showed evidence of MBD. Both had poor motor coordination, delayed developmental milestones, and hyperactivity. The children had average IQ scores, but they had perceptual difficulties, concrete thinking, and rotation problems. The parents had attempted to handle these boys as normal children, unaware that they had special needs. It is possible that they turned to each other for extra support.

Although these 2 cases were the only ones in which the referral was for intertwin problems, we found during the evaluations that 12 other twin relationships were described as problematic. Two twin pairs showed excessive rivalry and 10 pairs showed dependency of 1 or both twins.

Of the 6 twins who showed one-sided dependency, the dependent child was the 1 who was referred for evaluation. The independent twin of these pairs was not identified as having problems and was not referred to the clinic. The 4 children who showed mutual dependency were actually 2 sets of twins (i.e., both youngsters had been referred). In these cases, both children had some difficulties, although not necessarily of the same type. Thus it appeared that dependency in the twin relationship resulted in part from the child with difficulties turning to his twin for support. The following case illustrates this premise:

> Five-year-old Mike (not his real name) showed fear of school, unwillingness to separate from his mother, and increased dependency on his twin sister. Prior to this time, Mike had functioned quite independently of his sister, but simultaneously with the development of other symptoms, he began turning to her for a variety of needs. The evaluation disclosed that symptoms began to occur after Mike had been

hit by a schoolteacher. When Mike changed classes, all of his symptoms decreased, including the dependency on his twin sister.

DISCUSSION

We found that the majority of the 22 twins seen at a children's psychiatric clinic during a six-year period were referred because of learning problems and developmental delays. There was a significantly higher incidence of evidence of MBD in twins than in a matched control group; we feel that this difference is related to the "twin situation." It is possible that such factors as prematurity, birth difficulties, and fetal crowding—which are often inherent in twins—are crucial in the etiology of minimal brain dysfunction.

An unanswered question arising from our study is why such a comparatively small number of twins were referred to the clinic—half the number that would be expected on the basis of the incidence of twins in the general population. There is no easy, definitive explanation for this finding. However, one can speculate that the extra support provided by the twin relationship may have prevented more serious problems in some twins from becoming evident.

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Childhood Chemotherapy and Later Drug Abuse and Growth Curve: A Follow-Up Study of 30 Adolescents

BY LEAH BECK, M.D., WILLIAM S. LANGFORD, M.D., MARY MACKAY, M.D., AND GRACE SUM, M.S.W.

The authors studied the correlation of methylphenidate medication in childhood with later drug abuse and growth in height. Thirty adolescents with histories of minimal brain dysfunction who had been treated for at least six months with chemotherapy were compared with 30 adolescents who had not been so treated. The findings do not indicate that methylphenidate prescribed in childhood contributed to later drug abuse or seriously interfered with growth in height.

IN RECENT YEARS there has been increasing recognition and identification of children with minimal brain dysfunction (MBD). Treatment of these children generally requires a multiple approach that may include chemotherapy. Hyperactivity, irritability, disorganization, and a short attention span, which are among the cardinal symptoms of children with MBD, can often be reduced by a daily dose of methylphenidate. Other treatment approaches can then be more productive (1).

However, parents, legislators, and the general public have been concerned that the use of medication in childhood might ease the way to later drug use. A recent article (2) also questioned whether daily use of more than 20 mg of methylphenidate over a prolonged period of time might adversely affect a child's growth curve. Our study is an attempt to investigate the validity of these queries.

METHOD

We compared the current experience in the area of drug abuse of 30 adolescents with a childhood history of chemotherapy with an equal number of adolescents who had not been so treated.

Our study group was selected at random from former patients of the Children's Psychiatric Services of the Columbia-Presbyterian Medical Center in New York City.

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Adolescents included in the study group fulfilled the following criteria: they were between the ages of 14 and 19, which represents the age span of most active drug abuse, their chemotherapy during childhood lasted for at least six months, and they were not receiving this form of therapy at the time of the interview.

It has been noted (3) that the ratio of boys to girls who suffer from MBD is 4 to 1. Our random selection of 30 former patients reflects this ratio: 23 were boys with an average age of 16.4, and 7 were girls with an average age of 17.8. Intelligence ranged from 1 in the superior to 3 in the retarded-but-educable range, with the rest in the normal and dull-normal categories. All of the adolescents in the study group had documented evidence of MBD, and almost all had learning disabilities. Their socioeconomic levels ranged from ghetto poverty to lower middle class.

The control group of 30 adolescents, who were comparable in age, sex, and socioeconomic background but who had no history of chemotherapy, was drawn from medical and surgical inpatients of Columbia-Presbyterian Medical Center. None of the control adolescents suffered from chronic disabilities, and none had any previous psychiatric history.

The adolescents in both groups were interviewed individually to elicit their past and current use of drugs. In the case of the treated group, the interview probed not only drug use but also retrospective attitudes to methylphenidate medication. When possible, parents were also interviewed to corroborate findings.

RESULTS

Drug Use

The past and present drug use of the two groups is shown in table 1. It is apparent from the data that none of our former patients was currently addicted to heroin and that only 2 occasionally smoked marijuana. As they described it, the occasions on which they smoked were social in nature. One adolescent from a family with a history of drug problems had been habituated to heroin but had discontinued it two years before the interview.

Problems with drugs were more prevalent in terms of both past and present use and duration of use among the youngsters in the control group. One adolescent in this group had been a habitual glue sniffer for four years and then a habitual marijuana smoker for two years. The statistics of this population conform to the general findings of Wiener and Egan (4) concerning the amount of drug use among teenagers.

Growth Curve

We found that the use of methylphenidate had no perceptible effect on physical growth as measured by height. The height range of the former patients was 5 ft. 4 in. to 6 ft. 1 in. (average, 5 ft. 9.2 in.) for boys and 5 ft. 4 in. to 5 ft. 7 in. (average, 5 ft. 4 in.) for girls. The height range of the control group was from 5 ft. 4 in. to 6 ft. (average, 5 ft. 8.7 in.) for boys and 5 ft. 1 in. to 5 ft. 5 in. (average, 5 ft. 4.2 in.) for girls.

TABLE 1
Past and Present Drug Use of Two Groups of Adolescents

Drug Use	Number of Adolescents Who Used Drugs	
	Study Group (N=30)	Control Group (N=30)
More than six months before interview		
None	27	19
Marijuana occasionally	2	3
Marijuana habitually	0	1
Heroin occasionally	0	1
Heroin habitually	1	2
Hashish	0	1
Mescaline	0	1
Glue	0	1
Others	0	1
At the time of the interview		
None	28	22
Marijuana occasionally	2	3
Marijuana habitually	0	3
Heroin occasionally	0	1
Heroin habitually	0	0
Hashish	0	1
Others	0	0

General Functioning

Considering the handicaps that adolescents in the study group labored under during childhood and were continuing to deal with, their adaptation could be considered good. Twenty-three were still in school; 12 were in regular schools, 7 were in a special school or a special class, 1 was attending both regular and special classes, and 3 were in vocational schools. Of the 2 youngsters who had graduated from high school, 1 was employed and 1 was in college. Of the 5 who did not complete high school, 1 was attending night school, 1 was employed full-time, 1 was employed part-time, and 1 was unemployed.

COMMENTS

It would appear from this study that adolescents who received methylphenidate during childhood are no more susceptible to later drug use than adolescents in the general population. Actually, the reverse may be true.

Children who are receiving methylphenidate are eager to terminate the treatment in spite of their recognition of its positive effects. The experience of being controlled by medication apparently leads to later distaste of such restraint. Thus, contrary to general belief, early chemotherapy with methylphenidate appears to inadvertently offer a deterrent to the abusive use of drugs in late adolescence.

It has been our experience that patients with early organization problems are loath to renew any experience that may produce disorganizing effects—as is the case with marijuana or hallucinogenic agents. They are even inclined to avoid association with drug users because of their disorganized lifestyle.

It is our impression, based on EEG studies, that the development of the central nervous system is uneven in children with MBD. We have seen that this unevenness extends to physical growth in our years of clinical observation. While the overall height of the adolescents in our study group was comparable to the height of the adolescents in the control population, the former included some who were once considered small for their age or who experienced delayed puberty. Our evidence suggests that the physical growth of children with MBD may be governed more by the uneven growth phenomenon than by the use of methylphenidate medication (5). In the long run, however, the heights of the adolescents in our study group appear to be governed by the genetic determinants that govern height in the general population.

CONCLUSIONS

The fear that medication in childhood may ease the way to later drug abuse has not been substantiated by our data. As to possible adverse effects of methylphenidate medication on physical growth, no conclusive causal relationship was discovered. Maturational lags appear to extend to all aspects of growth in children with MBD. Although the current level of functioning of our study group has been good, we will have to wait until they reach adulthood to make a more accurate assessment of general adjustment.

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Platelet Monoamine Oxidase Activity in Acute Schizophrenia

BY WILLIAM T. CARPENTER, JR., M.D., DENNIS L. MURPHY, M.D., AND RICHARD JED WYATT, M.D.

The authors found normal monoamine oxidase (MAO) activity in 40 acute schizophrenic patients, in contrast to previous reports of a genetically linked platelet MAO deficit in chronic schizophrenia. Variations in MAO activity were not significantly associated with the 65 clinical variables analyzed, although there was a tendency for patients in the low-MAO group to have more severely impaired reality testing, more paranoid and grandiose delusions, better prognostic scores, and less restlessness.

DESPITE EXTENSIVE PSYCHOLOGICAL and biological investigations, the etiology of schizophrenia remains unknown. However, studies with twins and adoptees have indicated that schizophrenic vulnerability is, in part, genetically transmitted (1). A consistent biological marker—whether etiological or an epiphenomenon—would be welcome because it could serve as a validating criterion in sorting out the diagnostic puzzle surrounding schizophrenia.

Recent reports have indicated that a marked reduction of monoamine oxidase (MAO) activity in blood platelets has promise as a laboratory indicator of schizophrenic vulnerability. Murphy and Wyatt (2) found lower platelet MAO activity in 33 (predominantly chronic) schizophrenic patients compared to controls. Two-thirds of these schizophrenic patients had enzyme activity in the same low range that is found in individuals receiving MAO inhibitors. In a subsequent report, Wyatt and associates (3) replicated these findings with 13 monozygotic twins discordant for schizophrenia, suggesting genetic control for the MAO deficit. However, the 4 index twins in that study with a diagnosis of acute (rather than chronic) schizophrenia had normal platelet MAO activity. Using multiple substrates, Meltzer and Stahl (4)

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found reduced platelet MAO activity in acute and chronic schizophrenic patients compared to controls, with differences in substrate specificity differentiating the acute from the chronic patient groups.

We will examine two issues in this report: Do acute schizophrenic patients have a deficit in platelet MAO activity? Is platelet MAO activity associated with clinical status, premorbid features, family history, or one-year outcome in acute schizophrenic patients?

METHOD

Subjects

The 44 schizophrenic subjects in this study were hospitalized at the National Institutes of Health Clinical Center on an inpatient unit designed for the treatment and investigation of acute psychoses. Patients were admitted early in a psychotic episode if the presumptive diagnosis was schizophrenia. They were free of organic disease, were between the ages of 18 and 60, and manifested delusions, hallucinations, and/or a thought disorder. Their work and social functioning between episodes of illness was generally adequate. Most had been briefly exposed to medication before their admission.

The presumptive diagnosis of schizophrenia had been made on admission by our screening personnel and the outside referring physician. The diagnoses used in this study were made by the senior psychiatric investigator in the program following the admission conference in which all relevant data obtained during a three-week workup were presented, including the results of a semistructured mental status examination, the Psychiatric Assessment Interview (PAI). (This is a slightly abridged version of the Present State Examination, which has been thoroughly described elsewhere [5, 6].) Diagnoses were made using *DSM-II* (7) criteria and categories and were reinforced by applying a 12-point system for identifying schizophrenic patients (8). All diagnosed schizophrenic subjects admitted during the study period were included.

In this study, "chronic" denotes an established pattern of illness with poor prognostic features and prolonged social handicap; "acute" refers to patients with good prognoses studied early in a psychotic episode. The majority of the acute patients had had previous psychotic episodes which had remitted; these patients demonstrated intervening adequacy in work and social functioning. The acute patients generally had flagrant symptomatology and did not have defect symptoms such as "burnt-out affect." There were 40 acute schizophrenic patients, who were diagnosed as falling into the following *DSM-II* schizophrenia subtypes: 27 were classified as undifferentiated, 1 as catatonic, 8 as paranoid, and 4 as schizoaffective. There were 4 chronic schizophrenic patients. (Patients diagnosed as borderline were not included in this study.)

The subjects (25 female and 19 male) had a mean age of 23 years (SE = 1.05). Ten subjects were married; 34 had never married.

Clinical Variables and Data Collection

Many clinical variables other than diagnosis were examined in relationship to platelet MAO. The PAI was used to ascertain a detailed sign and symptom picture covering a one-month period. Information from the 240 items in the PAI is used to determine the presence or absence of Schneider's first-rank symptoms (9, 10), the score on a 12-symptom system designed to estimate the degree of confidence in a schizophrenic diagnosis (8), and the extent of symptomatology across 27 psychopathologic dimensions (e.g., depression, auditory hallucinations, incomprehensibility, bizarre behavior).

A Phillips scale (11) was rated by the patient's psychiatrist, and the patient cohort was dichotomized into process and reactive groups as recommended by Garmezy (12). A prognostic scale described elsewhere (13) was scored by the project's psychiatric social worker after extensive contact with patient and family and following a semistructured psychiatric history and social description interview with each patient near discharge.

Patients were seen for follow-up evaluation 1 year after admission (maximum patient stay was 4½ months), at which time a psychiatrist administered the PAI and a follow-up psychiatric and social description interview and then rated an outcome scale (14).

This systematic clinical data collection provided the 65 clinical, premorbid, outcome, and family history variables we analyzed for this report, which are listed in appendix 1.

Blood was collected during the patient's third week in the hospital and platelets were prepared as described previously (2, 15). Monoamine oxidase activity was determined using ^{14}C-tryptamine as substrate (2, 15). At the time of venipuncture, patients were acutely symptomatic and were in their third drug-free week. The platelet MAO assays were done by an experimenter who was unaware of their origin, and biological and behavioral data were kept completely independent until prepared for data analysis.

Data analysis was done by diagnostic groups (e.g., schizophrenic versus normal), by diagnostic subgroups (e.g., acute versus chronic), and by dichotomizing the schizophrenic cohort into high normal (≥ 5.0) and low (<3.0) platelet MAO activity (expressed as nanomoles per milligram per hour). The rationale for this division appears elsewhere (16).

RESULTS

Mean platelet MAO activity for the 44 schizophrenic subjects was 5.16 (SE = 0.32). This is not significantly different ($p<.2$) from a large control group of normal subjects (N = 131) whose mean MAO activity was 5.24 (SE = 0.20). No patient had a mean MAO activity less than 2.00. MAO activity in the 4 schizophrenic patients designated as chronic (mean = 4.94, SE = 0.29) did not differ from the 40 other schizophrenic subjects. Dividing the acute schizophrenic cohort into those receiv-

ing an undifferentiated (N=27) or schizo-affective (N=4) subtype diagnosis versus the 13 patients receiving another subtype designation resulted in slightly different MAO activities, with lower values in the latter group (means=5.52 and 4.31, respectively; SEs=0.41 and 0.35; t=2.18, d.f.=42, $p<.05$).

The relationships between platelet MAO activity and the 65 clinical variables listed in appendix 1 were examined by dichotomizing the patients into groups with low (<3.0) and high normal (≥5.0) MAO activity. In an analysis of variance between the 6 low-MAO and 15 normal-MAO patients, no variable attained statistical significance as a discriminator. Impaired reality testing (more severe in the low-MAO group) was the best discriminator ($F=4.1$, $p<.10$). Other variables with F values higher than 2.0 (not significant in a small sample but potentially discriminating) were 1) more paranoid and grandiose delusions, 2) better prognostic score, and 3) less restlessness, all in the low-MAO group. A step-wise discriminant function analysis with equal weight given to the low-MAO and normal-MAO groups resulted in a correct identification of 6 of 6 low-MAO patients and 11 of 15 normal-MAO patients with two variables, impaired reality testing and prognostic score.

DISCUSSION

In contrast to reports (2, 4) of reduced MAO activity in chronic schizophrenia, our results in 40 acute schizophrenic patients of several subtypes provide strong evidence against a platelet MAO deficit in this diagnostic subgroup. The mean MAO activity for these patients was not different from a large control group studied in the same laboratory and was decidedly higher than a group of 17 chronic schizophrenic patients not on drugs whom we studied previously (2) (mean=2.63, SE=0.61). This conclusion is enhanced by the finding that none of the 40 acute schizophrenic patients in this study had MAO activity less than 2.00, whereas 40 percent of the chronic schizophrenic patients and 10 percent of normal subjects were in that low range (16).

With increasing attention directed toward the relationship between acute and chronic schizophrenia, a genetically controlled enzyme deficit found in one group can provide specific information regarding the biological similarity of the two groups. Traditionally, acute and chronic have been considered time-related dimensions of the same illness, both falling conceptually within the "group of schizophrenias." Thus, genetic components of acute and chronic schizophrenia have been assumed to overlap. However, recent data from Danish studies with adoptees (1) suggest that acute and chronic schizophrenia may be different illnesses. Biological families of chronic schizophrenic adoptees were positive for schizophrenia and schizophrenic spectrum disorders, whereas biological families of acute schizophrenic adoptees were not. The preponderance of affective illness in families of acute schizophrenic patients and of schizophrenic illness in the families of chronic schizophrenic patients further supports this distinction (17).

The literature on platelet MAO activity in acute schizophrenia is equivocal and sparse. The only study (4) specifically contrasting MAO in acute and chronic subjects found 12 chronic schizophrenic patients significantly lower in platelet MAO on four substrates than were 15 control subjects. Ten acute schizophrenics were lower than controls on only two substrates and had values intermediate between chronic schizophrenics and controls on all substrates. In the monozygotic twin study discussed previously (3), the 4 index twins with an acute schizophrenic diagnosis had normal platelet MAO activity.

Since the patients in our schizophrenic cohort had normal mean MAO activity, we chose to dichotomize the patients into those with low and clearly normal enzyme activity. This division provides the best opportunity for assessing the relationship of low MAO activity to sociodemographic, premorbid, clinical, outcome, and family history variables. When the 65 clinical variables were examined with an analysis of variance between patients with low versus normal MAO activity, no variable had significant discriminatory power. There was an interesting tendency for patients in the low-MAO group to have more severely impaired reality testing, more paranoid and grandiose delusions, better prognostic scores, and less restlessness.

Our primary conclusion is that the 65 clinical variables we examined do not relate to MAO activity. However, because the number of low-MAO patients in our sample was small, the question of clinical predictors of MAO activity (other than diagnosis per se) remains open.

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APPENDIX 1

Variables Used in Analysis of Variance Between Groups with Low Versus Normal Platelet MAO Activity

1. Age
2. Marital history
3. Socioeconomic class
4. Family history of mental illness
5. Patient history of alcohol abuse
6. Patient history of drug abuse
7. First-rank symptoms present
8. 12 differential symptoms
9. Phillips Scale score
10. Age at onset of psychiatric symptom
11. Age of first psychiatric hospitalization
12. Duration of previous hospitalization
13. Number of prior psychiatric hospitalizations
14. Paranoid versus nonparanoid
15. Work history
16. Personal social relations
17. Last treatment facility (type)
18. Antisocial behavior
19. Restricted affective expression
20. Severity of current subjective distress
21. Time since onset of first psychiatric symptom
22. Presence of thought disorder, hallucinations, or delusions
23. Presence of depression, hypomania, or mania
24. Precipitating events for present illness
25. Total prognostic scale score
26. Inability to experience pleasure
27. Excessive dependency
28. Absence of insight
29. Impairment of interpersonal relations
30. Impaired reality testing
31. Lack of impulse control
32. Impairment of stimulus barrier
33. Depression
34. Anxiety
35. Reported restlessness
36. Observed restlessness
37. Retarded speech
38. Psychomotor retardation
39. Hypomania
40. Somatic concerns
41. General suspiciousness
42. Observed belligerence
43. Reported belligerence
44. Obsessions
45. Sloppy appearance
46. Disorientation
47. Lack of insight
48. Depersonalization/derealization
49. Delusions of reference and persecution
50. Grandiose delusions
51. Delusions of passivity
52. Depressive and nihilistic delusions
53. Other delusions
54. Visual hallucinations
55. Auditory hallucinations
56. Other hallucinations
57. Bizarre behavior
58. Social withdrawal
59. Incomprehensibility
60. Nonsocial speech
61. Restricted affect
62. Labile affect
63. Incongruous affect
64. Delusions about hallucinations
65. Rapport

The Postdivorce Clinic

BY DAVID J. SHEFFNER, M.D., AND JOHN M. SUAREZ, M.D.

The authors describe a clinic that evaluates court-referred families who have child custody or visitation problems in the postdivorce period. A multidisciplinary staff uses interviews, auxiliary sources of information, and psychological testing to arrive at recommendations that often address issues not specifically mentioned in the legal proceedings, particularly regarding treatment for disturbed children. The authors suggest that the clinic is an example of an appropriate interaction between law and psychiatry.

POSTDIVORCE PROBLEMS involving children are often handled by the legal system, yet attorneys and judges have limited competence in this area due to their lack of training in the behavioral sciences. Psychiatrists and other mental health professionals have been reluctant to enter this legal-psychiatric morass because they share the traditional irrational fears and disdain of the medical profession regarding involvement in legal conflicts. Their prototypical interaction with attorneys has been the malpractice suit; physicians share the universal trait of being anxious about processes they do not understand.

The courts have lacked the benefit of professional evaluation and treatment of the human problems behind the legal issues, and their decisions therefore often involve magical expectations. These decisions may provide little or no mechanism for continued work with families who resort (repeatedly, in many cases) to legal means as a solution to interpersonal problems and whose children are at relatively high risk for the development of emotional disorders. In such cases, the legal questions (e.g., custody or visitation) are often of secondary importance, the primary issue being the necessity to resolve pathological family dynamics. An example of this is the situation in which both parents have fairly decent parenting ability and it often makes little difference to a child's development which parent he resides with. However, whether or not he is subjected to continuing conflict between his parents makes all the difference in the world.

We are convinced that legal answers to interpersonal and family conflicts are usually inadequate or only partial answers. Also, they usually fail to provide intervention and follow-up, two areas axiomatic to psychiatric practice.

Traditionally, court work in the postdivorce period has utilized mental health professionals in a perfunctory manner (if at all), and the quality of such intervention has often been substandard. For example, a psychiatrist may spend only 15 minutes with the principals or make final recommendations without having interviewed both sides in a conflict.

The staff of the Section on Legal Psychiatry of the University of California, Los Angeles, Department of Psychiatry became involved with the domestic relations branch of the Los Angeles County Superior Court. This involvement resulted from our experience in which we had defined our role as that of behavioral scientist adviser to the court (as opposed to becoming involved in adversary and legal-moral issues) and from our interest in educating legal professionals as to the usefulness and the limitations of psychiatric knowledge and treatment. We developed a clinic in which extended evaluations, treatment, referral for treatment, and follow-up in the community are performed with families who have turned to the courts in the postdivorce period in an attempt to resolve their difficulties. In these families, the divorce has already taken place, usually several years ago. Even when we see parents in the original divorce proceedings, preserving the marriage is not an issue. Frequently we are dealing with a situation wherein one or both of the parents have remarried and there are children (or stepchildren) by their new spouse.

EXCERPTS FROM THE CLINIC CASELOAD

The following case fragments or vignettes provide specific examples of the problems that people bring to us daily at the postdivorce clinic.

A woman with three daughters who had a five-year history of cancer divorced her husband. The children, led by the oldest, refused to visit their father, who maintained that the mother was "mentally ill" as a result of her disease and treatment and sued for custody of the children. The court referred the family for evaluation. Our report suggested that it would be in the best interests of the girls to remain with their mother. However, a few months later the mother died. The father then had legal custody and moved back into the home. The children refused to have anything to do with him, and requested their relatives' permission to live elsewhere. The court sent the family back to our clinic for further evaluation and treatment.

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

At the time this work was done, Dr. Sheffner was Associate Director, Section on Legal Psychiatry, Neuropsychiatric Institute, University of California, Los Angeles, where Dr. Suarez is Director and Associate Professor, Department of Psychiatry. Dr. Sheffner is currently Clinical Instructor in Law and Psychiatry, Department of Psychiatry and Human Behavior, University of California, Irvine, 101 City Dr. South, Orange, Calif. 92668.

A woman who harbored much resentment toward her ex-husband influenced her young children against him. Both parents were well-functioning people and generally decent parents, except for the mother's irrational and destructive behavior in this one area. The children experienced considerable anxiety when visiting their father and wanted to discontinue their relationship with him altogether. The father came to the domestic relations court for help.

A couple with three daughters divorced, and each remarried. The man contended that his ex-wife's new husband was having an incestuous relationship with one of his daughters, and he attempted to obtain custody of all three of his daughters.

A young woman living an unstable and rebellious existence had a child out of wedlock. She gave her son to her parents to raise and did not visit him regularly or frequently. The parents began to obstruct her visitation and finally obtained custody of the child. Nine years later, this woman was living a more stable life and visiting her son regularly and was married to a man her son liked. The woman attempted to gain custody, and her parents opposed her.

A man got out of prison after serving a sentence for child molesting. His ex-wife refused to let him have any relationship with his children.

A black man and a white woman married and adopted a white baby. They divorced, and the father married a black woman. The father later sued for custody, alleging that his ex-wife had severely neglected and physically abused the young girl.

HOW THE CLINIC WORKS

These families are referred by the courts. Our staff consists of psychiatrists, psychologists, psychiatric residents, and social workers. We request (and are invariably granted) access to all historical information such as court investigators' reports, hospital and psychiatric records, probation reports, school reports, etc. In many cases we make direct personal contact with treating physicians, school personnel, friends, neighbors and other individuals able to offer insight into the current conflicts.

Although our emphasis is on the clinical evaluation, we welcome auxiliary information since we find that there are often limitations to the clinical interview; people involved in such litigation naturally tend to be defensive and to deny problems. We regularly see all the principals involved (parents, step-parents, and all but the very young children) and spend an average of 6 to 10 hours interviewing each family. Often we see the opposing parents together, a process of significant diagnostic value and occasionally of some initial therapeutic value. Screening psychological testing (the Minnesota Multiphasic Personality Inventory) is performed on all adults, and both adults and children are given more detailed psychological examination when this is indicated. The litigants are ordered by the court to pay the costs of the evaluation, which are on a sliding scale.

When the psychiatrist has completed his evaluation, the case is presented at a weekly interdisciplinary case conference where all those involved present their perspectives, the psychological testing is reviewed, and recommendations are discussed. A report to the court is then written and a copy sent to the attorneys, who are cautioned not to show the report to the parents in the interests of the children. In the reports we avoid psychiatric terminology and diagnostic labels. We often invite both attorneys together into our offices to discuss the situation, a process we consider mutually educational and one designed to facilitate the resolution of the issues. We have had considerable positive feedback from attorneys regarding these meetings. Negative reactions have usually been caused by an attorney's being unwilling to deviate from the narrowly defined role of advocate for his client.

Although we attempt to focus treatment on the totality of the situation, our basic therapeutic loyalties are to the children. Our child advocacy dovetails with the California courts' guidelines for resolving legal conflicts involving children according to the child's best interests. Some authorities in the field of family law suggest that the child's best interests would be furthered if the children were to have their own counsel. We disagree; we would view such a step as reinforcing the idea that legal solutions alone are sufficient. We also feel such a process would significantly complicate matters and would subject the children to further stress.

We view our role as quite activist. For example, we do not feel restricted to addressing the specific legal issues or questions asked by the court. Like professional consultants in any other field, we often redefine the problems or call attention to previously unseen issues. We have felt it entirely within our province, for example, to recommend a change in custody even though the legal issue was only one of visitation.

We have few theoretical guidelines other than helping to provide a situation that promotes the best interests of the children and attempting to deal with the human issues behind the legal ones. We do not view issues of criminal conduct, child beating, physical disability, race, homosexuality, and major psychiatric disorders (which we see often) necessarily as prime issues and we use no automatic guidelines in dealing with them. Our justification for spending the amount of time we do on every situation is that each is individual and unique. Our experience is that legal and mental health professionals who have absolute standards regarding such issues are either not sufficiently aware of the needs of children or have failed to appreciate the extreme complexity and difficulty of the problems involved and the relative nature of any assessments or recommendations made.

Our other activities include periodic meetings with the domestic relations court staff (judges, court investigators, and other court-appointed psychiatrists), case conferences, and educational programs. Because of financial and personnel limitations, we have no formal research program—a significant shortcoming that we hope to rectify.

THE CLINIC'S VALUE

In many cases we recommend to the court that some form of psychotherapeutic intervention be instituted. Although we had originally hoped to achieve some significant shift in the dynamics and behavior of pairs of contending parents, these hopes have not often been realized. Our explanation for this is the obvious one, namely, that we are seeing a select group of families whose attempts to resolve their conflicts by using legal leverage represent the persistence of major irresoluble issues or an inability to deal with problems in a realistic and appropriate manner.

Perhaps the most clear-cut value of our clinic is our regular evaluation and treatment referral of children who have been in very troubled situations and who display emotional difficulties but are not in treatment (often because of their parents' hostilities). The psychopathology of these children is often not evident enough to be noticed in the school setting. General psychiatric experience would indicate that such intervention constitutes a prime example of aggressive early detection and prevention of emotional disorders. The postdivorce clinic therefore performs a traditional public health function in a population that has not been readily accessible to the scrutiny of the health sciences.

Although we have no formal data yet to confirm that the courts view us as a valuable resource, their continued referral of a significant volume of cases and their willingness to participate in informal discussions and joint conferences appear significant. Although we hear from time to time of cases in which there has been a termination of a repeated pattern of court battles after our intervention, we have yet to do statistical analyses to confirm this.

For mental health professionals, students, attorneys, and judges, the postdivorce clinic offers a multitude of learning experiences in adult, child, and community psychiatry, family dynamics, and the legal and psychological difficulties of families in the postdivorce period. Also, it is a (perhaps unique) prototypical example of the appropriate interaction of law and psychiatry and provides an opportunity for appreciation and examination of the pitfalls and possibilities of working at the juncture of two complementary human disciplines.

Alcoholism and Forcible Rape

BY RICHARD T. RADA, M.D.

Data collected from detailed autobiographies of 77 convicted rapists revealed that 50 percent of them were drinking at the time of the rape and that 35 percent were alcoholics. This strong association between alcoholism and forcible rape highlights the importance of follow-up treatment programs for the alcoholic sex offender; such programs should focus on adequate control of his drinking behavior as well as on his sexual adjustment.

ALTHOUGH IT IS a widely held belief that alcohol lowers inhibitions of sexual behavior, enhances aggression, and is related to the commission of violent sexual crimes, few studies have reported on the relationship between alcoholism and forcible rape. In fact, the topic seems to have been overlooked by investigators of alcoholism and/or the sex offender. For example, in Macdonald's book *Rape: Offenders and Their Victims* (1), only 1½ of 321 pages are devoted to the specific topic of alcohol and rape. In Menachem Amir's report on "Alcohol and Forcible Rape" (2), only 2 of 28 bibliographic references are more recent than 1960.

A California report indicated that there was a five-year cumulative recidivism rate of 26.6 percent for all sex offenders and 35.6 percent for aggressive sex offenders (3). This recidivism rate, coupled with increased concern over the nation's alcoholism rate, emphasizes the importance of research into the possible relationship between alcoholism and rape. The purpose of this paper is to report on the alcoholism rate among 77 rapists committed to Atascadero State Hospital in California because of sex offenses.

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PATIENT POPULATION AND DATA COLLECTION

In 1954 the California state program for the treatment of mentally disordered sex offenders was initiated with the opening of Atascadero State Hospital. Because follow-up studies indicated a serious lack of successful treatment of the rapist, a separate program employing a 25-bed unit and a selected staff was established in 1968. Patient selection was based on the following two criteria: commission of forcible rape and little or no response to usual hospital treatment.

Each group of 25 patients was maintained on the ward for a six-month period, and a total of 100 patients were processed through the program over a period of approximately two years. The hospital used a multifaceted treatment approach; in addition, each patient was requested to complete a detailed written autobiography. Patients were given a five-page guide to follow in writing their autobiographies. In addition to discussing a variety of important personal topics, subjects gave a complete account of the commission of the offense, sexual history, all previous arrests and offenses, and past illnesses and medical history, including a discussion of use of drugs or alcohol or both.

Data on 77 of the 100 subjects were collected from a review of patients' autobiographies. (Seventeen subjects did not complete their autobiographies, and 6 provided insufficient data.) The data included age, marital status, religious preference, race, education, socioeconomic status (based on the Hollingshead and Redlich classification [4]), and history of their use of alcohol and drugs other than alcohol. Data on the use of alcohol included whether the subject was drinking at the time of the offense, and if so, an estimate of the degree of drinking, ranging from heavy to moderate to light. Heavy drinking was classified as 10 or more beers or the equivalent, moderate drinking, 5 to 9 beers or the equivalent; and light drinking, less than 5 beers or the equivalent.

A diagnosis of alcoholism was made on the basis of the patient's direct admission of alcoholism or any three of the following items: 1) previous arrests resulting from drinking and/or intoxication, 2) a history of arrests for driving while intoxicated, 3) admission of a history of heavy drinking with concomitant interpersonal and social maladjustment, 4) a history of delirium tremens or blackouts, 5) heavy drinking at the time of the commission of the offense, and 6) a history of seeking help or hospitalization for drinking problems. These criteria were considered stringent and are in keeping with those established by Selzer (5) and by the Criteria Committee of the National Council on Alcoholism (6).

RESULTS

Thirty-five percent (N=27) of the subjects were classified as alcoholic. Fourteen percent (N=11) of the 77 admitted that they were alcoholics. Fifty percent (N=38) of the sample were drinking at the time of commission of the offense: 43 percent were drinking heavily, 3 percent moderately, and 4 percent lightly. All of the alcoholic rapists were drinking heavily at the time of the offense. Only 22 percent of the nonalcoholic rapists were drinking at that time: 12 percent were drinking heavily, 4 percent moderately, and 6 percent lightly.

The demographic data revealed that in general, the alcoholic rapist was more likely to be married, Catholic, Mexican-American, and from socioeconomic group IV. In addition, he tended to be slightly older than the nonalcoholic rapist (mean ages=26.7 and 24 years, respectively) and had had slightly less education (mean grade levels=10.6 and 11.1 years, respectively).

Twenty-six percent of all subjects cited a history of prior use of drugs. The alcoholic rapists had a much higher rate than the nonalcoholic rapists (37 percent versus 20 percent). Only 12 percent of the total group were using drugs at the time of the offense. Again, the alcoholic rapists, in addition to their use of alcohol, were slightly more likely than the nonalcoholic rapists to be using other drugs (15 percent versus 10 percent).

Finally, only 3 of the 77 were using only drugs other than alcohol at the time of the offense; 2 of these were using only marijuana. In both groups, the use of harder drugs at the time of the offense was associated with the concomitant use of alcohol.

DISCUSSION

The Literature

Two basic theories have been suggested to explain the relationship between alcohol and the commission of sexual and/or violent crimes. The disinhibition theory, which has been advocated by several psychiatrists (7, 8), states that alcohol decreases ego control, numbs judgment, and releases normally present moral inhibitions. The other theory postulates that alcohol has a direct effect on brain centers responsible for sexual and/or aggressive behavior. This theory is supported by evidence that alcohol enhances the general level of activity (9), and it is therefore speculated that alcohol could energize aggressive behavior. There is, however, no satisfactory evidence to support either theory.

Research in the field of psychoendocrinology has opened new areas for investigation. Several investigators (10, 11) have studied androgens and aggression in human subjects and have suggested that there is a relationship between higher plasma testosterone levels and aggression and hostility. Mello and Mendelson (12) explored the general effects of chronic alcoholism and the direct effects of experimentally induced intoxication on serum testosterone levels. They found, however, that chronic ethanol ingestion was consistently associated with decreased serum testosterone levels, and they concluded that it is not possible to establish a simple relationship between the level of serum testosterone and aggressive behavior.

Reports in the literature on drinking, alcoholism, and

forcible rape are rare, and the findings are inconsistent. This is due in part to different methods of data collection and different criteria for the diagnosis of alcoholism. For example, reports on the incidence of drinking at the time of the rape vary from zero (13) to over 50 percent (14). The finding in this study that 50 percent of the rapists were drinking at the time of the offense certainly suggests an important but not necessarily direct or causal relationship between alcohol and rape.

This Study

Two factors in this study may have contributed to the finding that a high percentage of both groups were drinking at the time of the rape. First, the subjects were chosen for inclusion in the special treatment unit partly because they had not responded to the usual hospital regimes, and they therefore may have been a "sicker" than average group. Second, the rapist may cite the use of alcohol as an excuse for his offense, a fact that in itself suggests there is a common social and possibly legal acceptance of the disinhibition theory. Furthermore, even though 50 percent of the rapists were drinking at the time of their offense, this does not point to a direct or causal relationship between the two. This finding does not take into consideration many other factors, including the presence or absence of alcohol in the victim, the social context just preceding and at the time of the rape, and the possibility that a higher percentage of drinking offenders than nondrinking offenders are caught and brought to trial. Nevertheless, the high association between the two warrants more attention and investigation.

If the relationship between drinking and the commission of sexual crimes has received little study, the relationship between alcoholism and rape has received even less attention. The finding in this study of an alcoholism rate of 35 percent has important therapeutic implications. Regardless of one's theoretical position, every clinician is aware of the many legal problems frequently encountered by the alcoholic who has "fallen off the wagon." A follow-up program of treatment for the recovered alcoholic sex offender that focuses on his sexual adjustment without attending to his addiction-proneness is inadequate. It is, in fact, highly probable that in a high percentage of the cases, control of the alcoholic sex offender's drinking behavior would in itself result in a cessation of his sex offenses.

The relatively low mean age of the alcoholic rapist (26.7 years) again emphasizes that alcoholism is not simply a problem of the chronic, old skid-row alcoholic, and it stresses the importance of early recognition and prevention. Some of the subjects had a history of a steady progression of social maladjustment secondary to alcoholism, as well as a progression from lesser sex offenses (peeping tomism, exhibitionism) to the rape for which they were committed. This finding differs from those of other investigators who have concluded that the sex offender does not progress from less serious to more serious offenses (15).

Finally, the finding of greater drug use by the alcoholic rapist points to the multi-addiction-proneness of the alcoholic. The finding that only 3 subjects were using only drugs other than alcohol at the time of the rape supports previous evidence that use of hard drugs does not predispose to the commission of sexual crimes (16) but may, in fact, diminish sexual behavior and experience (17).

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Depression and Anxiety in Heroin Addicts: A Placebo-Controlled Study of Doxepin in Combination with Methadone

BY GEORGE E. WOODY, M.D., CHARLES P. O'BRIEN, M.D., PH.D., AND KARL RICKELS, M.D.

Narcotic addicts may manifest symptoms of depression that aggravate their addiction. In this double-blind study of 35 mildly depressed patients in a methadone maintenance program, subjects who received doxepin improved significantly more than control subjects. Even in this short-term study, the reduction in depression was associated with a trend toward better performance in other areas of rehabilitation.

CLINICAL CONTACT WITH heroin addicts gives one the impression that many use narcotics for relief of anxiety and/or depression (1). At times these symptoms are manifest; at other times they are present but masked. Patients who are receiving methadone treatment and who are feeling this way will often ask for a higher dose of methadone. This situation creates a management problem for the physician. Raising the dose of methadone will usually give relief, but this treatment is effective only until tolerance for the higher dose develops. When symptoms reoccur the cycle can repeat itself, with the dose going up and no long-term relief provided. Declining to raise the dose or trying to treat the patient with psychotherapy often results in the patient's making a "street buy" for self-medication.

The role of catecholamines in this cycle is not clear. The catecholamine hypothesis (2) associates decreased available catecholamines with depression. There is evidence (3) that catecholamine synthesis is increased as an acute effect of narcotics and that it is decreased during withdrawal. Addicts typically are going in and out of withdrawal; thus an overall decrease in catecholamine synthesis may be present and may contribute to the clinically evident depression.

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In such cases it seems reasonable to use an antianxiety or antidepressant drug. This treatment might alleviate the patient's symptoms, thereby avoiding an increase in methadone dosage or the use of illegal drugs.

Doxepin, a tricyclic antidepressant that has also been reported to possess at least some antianxiety effects (4–6), was chosen as the treatment agent. Open trials in our clinic suggested that the compound had some usefulness in certain methadone-treated patients, especially those with sleep disturbances. A placebo-controlled study was therefore designed to test the following hypothesis: Patients in a methadone treatment program with ratable depressive symptomatology should show more improvement when treated with doxepin than with placebo. Improvement may be manifested in one or more of the following ways: 1) reduction in need for methadone, 2) reduction in the use of illegal drugs, as measured by urine tests, 3) improvement in scores on depression rating scales (physician and patient ratings), 4) reduction in duration of need for methadone maintenance, 5) reduction in illegal activity (fewer arrests), and 6) improvement in social adjustment (in family and occupation).

METHOD

Male addicts between the ages of 20 and 50 who applied for methadone treatment at the Drug Treatment Center of the Philadelphia Veterans Administration Hospital were selected for the study. All subjects had to meet the following criteria for inclusion in the study: 1) fulfill Food and Drug Administration requirements for methadone treatment, 2) be medically healthy, 3) be free of addiction to drugs other than narcotics, and 4) be judged by a psychiatrist to be significantly troubled by symptoms of depression. Written informed consent was obtained for methadone treatment, and oral consent was obtained for participation in the doxepin study.

From 88 consecutive patients placed on methadone, 35 patients were selected and assigned at random to either doxepin (N=17) or placebo therapy (N=18), using a double-blind technique. The doxepin group had a mean age of 28.3 years and the placebo group, 29.1 years. The mean level of education for both groups was 11 years, and the unemployment rates for both groups at admission was about 70 percent. Patients who were just beginning methadone treatment were selected in order to control for length of time on methadone, and thus their motivation for continuing treatment was still in question.

Identical capsules containing either 25 mg of doxepin or placebo were used as the study medication. This medication was given in one daily dose together with the patient's daily dose of methadone, under direct observation. Doxepin was given in a dosage of 50 mg per day for 3 days, then increased in 25 mg increments, pending clinical response and side effects, up to a maximum of 150 mg per day. The minimum daily dose was 100 mg per day or four placebo capsules. Patients were assigned to a therapist and treated with counseling, group therapy, and vocational rehabilitation, as are all patients in the drug treatment program. Evaluations were conducted at admission and after 1, 2, 4, 8, 12, and 16 weeks of treatment.

Rating instruments consisted of the Beck Depression Inventory (13-item version) (7), the Zung Self-Rating Depression Scale (8, 9), and the Hamilton Depression Rating Scale (Early Clinical Drug Evaluation Unit, NIMH, version of 21 items) (10). The Beck and Zung scales were completed at intake and at each evaluation point; the Hamilton scale was completed at intake, 4 weeks, and at termination. Other intake information included a detailed history of drug use, social history, psychiatric history, and urine test screening for drugs. In addition to the rating instruments, the follow-up evaluations consisted of a psychiatric interview (monthly), a rating by a counselor (biweekly), urine testing (at least once a week), and a self-report of patient progress (monthly). In this manner we obtained information on drug use, employment, arrests, and family adjustment. Side effects and methadone dosage were recorded at weekly intervals. Rating scales were analyzed by covariance techniques and other data by chi-square analysis.

RESULTS

Dropout from the study was considerable, and only data from patients with at least 4 weeks of study treatment were used in the statistical analysis. It should be noted, however, that when one considers the number of patients remaining in the double-blind study for longer than 4 weeks (i.e., 8 to 16 weeks), there is a trend ($p<.20$) toward greater retention of doxepin patients ($N=10$, or 59 percent) than placebo patients ($N=6$, or 33 percent). The reasons for dropping out were often not drug related, e.g., incarceration or hospitalization for a medical problem. Patients were considered dropouts when they left the double-blind study; they did not necessarily leave the methadone program. These high dropout rates are close to those seen in low social-class clinic patients (11).

Despite the fact that doxepin was given in a single daily dose, only two patients dropped out because of side effects. One said that he felt "speeded-up" and the other complained of sedation plus a "speedy feeling." One placebo-treated patient had to be dropped because he developed a dystonic-like reaction. He was continued on methadone without further side effects.

Initial psychopathology scores, given in table 1, indicate that the mean score of 9.10 for the 13-item Beck scale is almost identical to the mean score of 9.37 given by Beck and Beck for mildly depressed patients (7). Similarly, the initial mean index score of 58 on the Zung scale is close to Zung's mean index score of 60 for neurotic depressed patients (8). Thus our subjects did indeed suffer from at least mild symptoms of depression.

Depressive symptoms decreased significantly more on doxepin than on placebo and this difference was consistent in both patient and clinical measures (table 1). This was particularly obvious in the area of anxiety/depression, according to both the Hamilton and Zung scales as well as the total Beck scale.

These questionnaire data were supported by the patients' monthly ratings, which showed that the doxepin group improved significantly more than the placebo group in nervousness ($p<.025$) and craving for heroin ($p<.05$).

Since the retardation/apathy factor of the Hamilton scale had a relatively low initial score, we compared the regression slopes of both groups and found that the slope of the doxepin group was significantly shallower than that of the placebo group, thus providing a significant heterogeneity of regression ($F=14.73$, $df=1,18$, $p<.005$). In other words, those patients who had measurable symptoms of retardation and apathy improved significantly more on doxepin than on placebo, while there was no difference between treatment modalities in patients with only slight symptoms.

We attempted to compare the performance of patients in each group in regard to drug-seeking behavior and level of methadone dose. Among the doxepin patients, 11 of 16 had "clean" urines more than 50 percent of the time, while only 7 of 16 placebo-treated patients met this criterion. (One doxepin and 2 placebo patients are not included here because they were very early dropouts.) In addition, 3 doxepin patients had their methadone doses reduced during the study, while none of the placebo patients did. These differences do not reach conventional levels of significance, and they are very difficult to evaluate because of the many uncontrolled variables that influence urine test results and methadone dose.

There was a significant difference between the two groups in self-reported use of amphetamines. When patient reports at end point were examined, all 13 remaining doxepin patients reported no use of amphetamines, compared with only 6 of the 11 placebo patients ($\chi^2=4.96$, $p<.05$). This was not borne out by urine test results, but our laboratory was undergoing technical problems at this time and we were unable to get accurate urine test results for amphetamines. The patient self-reports were so strikingly different that we feel this finding should be examined more carefully in a larger study. This apparent reduction in amphetamine abuse is in keeping with the findings on the depression scales. Doxepin-treated patients felt less depression and thus felt less need for "speed." The reported use of alcohol and barbiturates was also less in the doxepin-treated group, but this difference was not significant.

No adverse interactions were noted between doxepin

TABLE 1
Clinical Improvement After 4 or More Weeks of Treatment

Factor	Pretreatment Mean (N=35)	Adjusted Mean: Doxepin Group (N=13)	Adjusted Mean: Placebo Group (N=11)	F Ratio	Level of Significance
Hamilton Depression Rating Scale (Range: 0–62)*					
Sleep disturbance	1.45	0.49	1.04	2.51	n.s.
Somatization	0.95	0.48	0.70	0.97	n.s.
Anxiety/depression	1.00	0.39	0.89	7.67	.025
Retardation/apathy	0.79	0.38	0.44	0.12	n.s.
Anxiety cluster	1.48	0.72	1.09	1.70	n.s.
Total score (Index)	0.87(18.3)	0.34(7.1)	0.72(15.1)	4.25	.06
Beck Depression Inventory (Range: 0–39)*					
Total score	9.10	3.64	10.27	14.41	.005
Zung Depression Scale (Range: 1–4)*					
Retarded depression	2.57	2.34	2.53	0.47	n.s.
Anxious depression	2.01	1.52	2.06	14.84	.005
Total score (Index)	2.28(58)	1.99(50)	2.32(58)	3.52	.10
Patient's monthly report					
Craving for heroin (N=17) (Range: 1–5)*	2.24	0.29	1.30	5.89	.05
Nervousness (N=10) (Range: 1–5)*	3.00	2.32	3.69	6.54	.025

*Higher scores indicate more pathology.

and methadone. There were also no adverse reactions reported when patients used illegal drugs while receiving doxepin.

DISCUSSION

These data, although preliminary, represent one of the few double-blind placebo-controlled studies of a tricyclic antidepressant in methadone-treated addicts. We encountered several problems in the design of the study and believe that some changes should be made in any future more definitive study. The present data show a significant advantage for methadone maintenance patients who receive doxepin over those receiving placebo. This advantage is statistically significant when measured by both patient reports and psychiatric ratings. Nevertheless, these data should still be considered only preliminary because of the relatively small number of patients who completed the study. The high dropout rate and relatively short duration of treatment prevented us from obtaining useful data on such outcome measures as contact with law enforcement officers, occupational adjustment, family adjustment, and ability to withdraw from methadone. Only a long-term study of possibly 5 to 6 months will provide answers to these questions.

The high dropout rate that we encountered was a difficult problem. However, even in neurotic nonaddict patients of a social class similar to that of our patients, high dropout rates have been observed, particularly early in treatment (11). Our study involved patients who were just beginning methadone treatment, and thus a high dropout rate is not surprising. Even though most of the patients appeared genuinely depressed, some were not really motivated for treatment, and they may have enrolled in the program merely to obtain favorable consideration in the legal system.

A subsequent more definitive study should involve a larger number of patients over a longer treatment period. A significant dropout rate would still be expected if newly admitted patients were used as the study population. A large initial sample, however, would permit a determination of the effects of a tricyclic antidepressant in possibly reducing the high initial dropout rate. This possibility is suggested by our findings because of the trend toward a lower dropout rate for the doxepin patients. The longer time period and larger sample would also be more likely to produce meaningful data on measures of employment, illegal activity, family adjustment, and ability to withdraw from methadone. A technical improvement would be the use of liquid doxepin (or another tricyclic antidepressant) rather than the capsule form.

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A Comparison of Traditional and Symptom-Checklist-Based Histories

BY CARLOS E. CLIMENT, M.D., ROBERT PLUTCHIK, PH.D., HAROLD ESTRADA, M.D., LUIS F. GAVIRIA, M.D., AND WILFREDO ARÉVALO, M.D.

The authors compared the results of independent evaluations of 96 patients, each of whom was given a traditional psychiatric interview, resulting in a narrative report, and a structured interview based on a self-report questionnaire, resulting in a standardized report. Although the latter method produced a higher frequency of report of all symptoms, the overall accuracy of diagnoses was similar for the two methods. The authors enumerate the potential benefits of the use of standardized histories.

THE PAST DECADE has seen a rapid increase in the use of standard recording instruments in psychiatry and of associated computer technology (1, 2). This change reflects the fact that there are large numbers of patients but comparatively few trained psychiatrists in the mental health delivery system. Because the time available to psychiatrists for patient contact is relatively limited, it must be used as effectively as possible. There would be considerable advantage if some of the time the physician spends obtaining a traditional psychiatric history and writing a narrative report could be used for therapeutic or other types of activities.

The present study was designed to compare the kind of information obtained in a traditional psychiatric history interview with that obtained through the use of a standardized questionnaire.

In 1970, Meikle and Gerritse (3) reported a study that had a similar aim. They found that the reported frequency of psychiatric problems obtained through a standardized questionnaire was greater than that obtained through narrative records. However, their comparisons were made on two different groups of patients, which confounded differences due to measuring instruments with those due to individual differences in patients. In our study, we used one large group of patients who were evaluated independently by two different methods. In addition, the relative accuracy of diagnoses and treatment plans resulting from narrative and questionnaire methods was determined by a panel of experts.

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The authors wish to thank Drs. Ernesto Zambrano and Guillermo Calderon, Directors, San Isidro Psychiatric Hospital, for their collaboration in this study; Dr. Jaime Salazar for his cooperation in the initial development of the study; Sisters María Olga Franco and Teresa Mora, Ms. Myriam de Castillo, and Ms. Martiza Gil, Chiefs, Outpatient Service, San Isidro Psychiatric Hospital, for their collaboration in the data collection; and Mr. Gustavo Chyca for assistance in tabulation of the data.

METHOD

The study was carried out in the San Isidro Psychiatric Hospital in Cali, Colombia, a university center affiliated with the Department of Psychiatry, Universidad del Valle. This hospital serves a population of about three million people. Treatment is carried out by trained medical interns who systematically rotate through the hospital and who are under the supervision of the staff of the Department of Psychiatry. In addition, first- and second-year psychiatric residents provide limited services.

These interns were given extensive training in psychiat-

ric interviewing before they were asked to collect data. It has been our experience that the psychiatric histories obtained by these interns are as complete as those obtained by more experienced psychiatric residents.

The items for the questionnaire were obtained through a review of studies in the English language (1, 4, 5) and systematic examination of 100 randomly selected psychiatric histories. The questionnaire went through several stages of development and benefited from a number of meetings with the staff of the hospital at all levels and from interviews with patients and relatives.[1]

The study population consisted of 96 consecutive new patients who came to the hospital during a period of one month. Each patient was evaluated independently by two different groups of physicians in the emergency room of the hospital. Because of practical limitations related to the period of time of rotation through the hospital, the number of evaluators for each method was different.

A group of six interns used the traditional narrative method to report data gathered during the traditional psychiatric interview. The average time to complete the interview and write the narrative report was about an hour and a half. A second group, consisting of one intern and one second-year resident, used the questionnaire method. None of the evaluators using either method knew what the goals of the study were. Members of the questionnaire-method group were instructed to carry out an interview and psychiatric evaluation in the traditional fashion and to report their findings through the use of the standardized questionnaire.

The order of events was as follows: the patient arrived at the hospital and was seen by the physician in the traditional interview, and an evaluation, a diagnosis, and a treatment plan were formulated. At this point, the patient was given a questionnaire that contained a series of questions about his psychiatric problems, to be answered simply yes or no. A clerk, using a separate questionnaire, obtained demographic data on each patient. Once these questionnaires had been completed, the patient was interviewed briefly by a second physician who, after reading the patient's answers and demographic background, completed his own questionnaire regarding the mental status of the patient, including his diagnoses and recommendations. The physician took about 15 minutes to complete the interview and the standardized questionnaire.

The narrative reports on the 96 patients were systematically reviewed by a research assistant who was unaware of the purpose of the study. Using the information found in the narratives, he completed the same questionnaires that were originally filled out by the second physician as fully as possible.

For a random subsample of the records, one of us (C.E.C.) independently transcribed the narrative data to the questionnaire and found almost 100 percent agreement, indicating that the method of transcription was highly reliable.

[1]Copies of the questionnaire may be obtained from Dr. Climent.

TABLE 1

Percentage of Patients Showing Psychiatric Symptoms: Narrative History Versus Standardized Questionnaire

Symptom	Narrative Report	Questionnaire
Patient self-report		
Insomnia	35.0	54.1
Homicidal acts	41.6	54.1
Weight loss	1.0	51.0
Depression	35.4	51.0
Anxiety	16.6	49.9
Suicidal thoughts	15.6	45.8
Anorexia	19.8	42.0
Delusions of persecution	12.5	36.4
Homicidal thoughts	12.5	27.0
Suicidal acts	12.5	26.0
Hysteria	0.0	22.9
Convulsion	7.3	22.9
Communication with God	3.1	21.8
Marijuana use	7.3	14.6
Delusions of grandeur	2.1	12.5
Weekly alcoholism	1.0	8.3
Obsessive behavior	2.1	8.3
Use of drugs	2.1	5.2
Daily alcoholism	1.0	4.2
Frequently drunk	1.0	2.1
Psychiatrist's evaluation		
Concentration problems	1.0	55.1
Confusion	23.9	54.1
Ideas of reference	3.1	53.0
Inappropriate affect	35.4	51.0
Hypochondriasis	6.2	47.8
Inappropriate behavior	23.9	46.8
Hostile behavior	13.9	45.8
Hallucinations	19.7	37.4
Delusions of control	3.1	36.4
Euphoria	12.9	32.2
Psychomotor retardation	8.3	30.2
Incoherence	13.9	30.0
Sexual problems	9.4	29.1
Inappropriate dressing	3.1	9.4

RESULTS

Table 1 shows the symptoms reported on the basis of the narrative report in comparison with those reported via the questionnaire. All of the 36 symptoms or problems listed in the questionnaire—obtained either from the patient directly or through the doctor—were reported more frequently through the use of the questionnaire than the narrative report. This discrepancy was most marked for such symptoms as concentration problems, hypochondriasis, and anxiety. Suicidal thoughts were reported three times more often by the questionnaire method than by the narrative.

There were 52 total agreements, 19 total disagreements, and 23 partial agreements of diagnoses on the two types of histories. (Not all cases had a diagnosis and treatment recommendation.) Diagnoses were considered to be in partial agreement when, for example, the specific type of diagnostic subcategory was different but the general group was the same, e.g., catatonic schizophrenia versus paranoid schizophrenia. Total dis-

agreements were judged when the major *DSM-II* (6) classifications were different.

The 19 disagreements raised the question of which of the two methods, narrative or questionnaire, was more correct. This could be determined only by reference to the judgments of experts, i.e., experienced psychiatrists. The 19 cases of disagreement were therefore reviewed by two experienced psychiatrists who did not know the purpose of this study and who reviewed the records and questionnaires without seeing the written diagnosis or treatment plan. They were asked whenever possible to make one final diagnosis and to formulate a treatment plan.

In addition to information regarding diagnosis and treatment, the name of each patient was carefully concealed for the purpose of this review. In cases where the two experts disagreed with one another, they were brought together for discussion until a final decision was reached. The results of these 19 evaluations were as follows: in 2 cases it was impossible to arrive at a diagnosis after reviewing the information, in 8 cases the diagnosis was identical to that obtained using the traditional method, and in 9 cases the final decision agreed with the questionnaire method.

To summarize, in the cases in which there was disagreement between the two methods (approximately 20 percent), the experts agreed with half of the diagnoses made by the narrative method and half made by the questionnaire method. Thus, the two methods were similar in the overall accuracy of diagnosis, and there is therefore no advantage in using one or the other method if the desired end result is simply a psychiatric diagnosis.

A similar analysis was performed in regard to treatment plans. Here again, there was no difference between the narrative and questionnaire methods in producing treatment plans that were consistent with the judgment of experts.

DISCUSSION

The results we have reported clearly indicate that the use of a structured questionnaire produces more specific information about each patient than does the more traditional narrative. The use of the questionnaire more frequently identified each of the 36 items descriptive of psychopathology as characteristic of the 96 patients than did the narrative. For some items (e.g., concentration problems, ideas of reference, and weight loss), there was a discrepancy of more than 50 percent between the two methods. For low-frequency items (e.g., use of drugs, frequently drunk, and daily use of alcohol), the discrepancies between the two methods were slight.

The cause of such discrepancies is not evident from our data. It is not known whether the psychiatrist using the narrative method did not inquire about a particular symptom, did not notice it, or did not write it in his narrative report even if he did notice it. The psychiatrists using the narrative method might have felt that it was a waste of their time to note every symptom when the purpose of the interview was to formulate a diagnosis, not a catalogue of symptoms.

The two methods were in complete agreement on 54 percent and in partial agreement on 23 percent of the diagnoses. This suggests that agreement on diagnosis can be reasonably high even when agreement on specific symptoms is low.

A similar conclusion follows from the data on treatment plans. There was complete agreement 49 percent of the time and partial agreement 21 percent of the time, suggesting that agreement on treatment plans can be moderately high even when agreement on specific symptoms is low.

One issue that might be raised is whether the interns and residents who carried out the study were sufficiently skilled in psychiatric evaluation to provide reasonably complete reports. Although we cannot give a definitive answer to this question, we would note the following facts:

1. All medical students at the university have at least one course in psychology or psychiatry each year of their medical school training.
2. Each intern spent one full month in the psychiatric hospital and then had a six-week period in the psychiatric hospital before participating in the study.
3. Each case was supervised by a senior staff member.
4. All staff members had completed adequate training programs at well-recognized teaching centers and had sufficient clinical and academic experience.

It therefore seems likely that the interns and residents involved in the study were reasonably well trained and that any other group of interns and residents would have obtained comparable results.

Another issue that might be raised is whether or not the narrative history covers items of information not covered by the questionnaire. This, however, is unlikely because the questionnaire items were selected by a group of experienced psychiatrists and were designed to cover all areas usually considered to be important in a psychiatric interview. In other words, the items of the questionnaire were considered by competent psychiatrists to be an appropriate sample of the universe of psychiatric items and therefore had content validity.

An additional issue concerns the usefulness of the questionnaire. It has been demonstrated that there is no advantage in the use of either method in producing a diagnosis or a treatment plan that is consistent with the judgment of experts. However, there is a great difference in the time factor: while the narrative interview and evaluation takes more than an hour of the psychiatrist's time, the evaluation through the use of a patient self-report plus a questionnaire requires only 15 minutes.

In the light of the results we obtained in this study, we feel that there are several reasons why a structured questionnaire like the one used in this study is preferable to the traditional narrative report.

1. It provides the physician with a rich group of psychiatric symptoms, otherwise ignored in the traditional psychiatric histories.
2. The questionnaire is an objective, standard, and

replicable method that can be easily used to summarize information on groups of patients through the use of computers.

3. The questionnaire takes less time to complete but provides more detailed information than the narrative history.

4. The questionnaire is a useful training device for students or residents in that it directs their attention to important areas that need to be evaluated.

5. Use of the standard form assists the supervisory psychiatrist by bringing to his attention "blind spots" in a student's approach to patients or to weaknesses in the student's evaluation skills.

6. A portion of this particular questionnaire actively involved the patient in the data-gathering process. This active participation was positively received by patients and relatives who interpreted it as indicating that the hospital staff had a special interest in them.

Two suggestions were made by the interns, residents, and experts about the questionnaires. One was that the self-descriptions of patients should be rated on a graded scale rather than by a yes/no category. This would help distinguish important problem areas from unimportant ones. Also, the physicians all felt that some brief descriptive written comment was necessary to provide future readers of those questionnaires with a more complete picture of the patient and his circumstances. This could be much briefer than the traditional narrative but should not be entirely eliminated.

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Similarities Between Parents and Offspring on a Personality Inventory

BY ROBERT E. PECK, M.D., AND JOHN E. EVERSON

The authors administered a personality inventory that has been used as a psychiatric screening test to 28 children and their natural parents. By intercorrelations between the tests of parents and offspring they attempted to find out whether the offspring resembled the parent of same sex, the parent of the opposite sex, or a composite of both parents. They found that the offspring resembled their peer group more often than either parent or a composite of both parents.

FOR THE PAST SEVERAL YEARS we have been interested in exploring various uses of a psychiatric screening test known as the Adjective Inventory Diagnostic (AID) (1). We have found it to be useful in pinpointing psychopathology in a patient's family. Inasmuch as the test consists of self-descriptive adjectives that are rated as to degree present, it seemed reasonable that intercorrelations might indicate important similarities between parents and their offspring. This assumption is eminently reasonable because the correlation coefficient is one of the few multifactorial measurements capable of indicating similarities and the best for giving an overall profile of a person (2).

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METHOD

We administered the AID to two natural parents and one or more children in 28 families. We then chose one child and both parents for the experiment. We tried to select an approximately equal number of nonpatient (N = 17) as well as patient (N = 11) offspring. In some of the families a parent was the patient. There were more male offspring (N = 17) than female (N = 11). Ages for the male offspring ranged from 11 to 42 with a median of 21; for the females the range was 15 to 23 and the median 18.

The AID of each offspring was correlated with that of the mother and father separately and then with a composite of both parents' tests formed by adding the matrix of each and dividing by two. As a control, a number of other matrices were created, and each child's AID was correlated with each of these. The other matrices were, respectively, all female offspring combined, all male offspring combined, all mothers combined, and all fathers combined.

The results of the experiment can be summarized[1] as follows: the frequency of highest resemblance of daughter to peer group was 6; of son to peer group, 16; of daughter to mother, 4; of daughter to father, 1; of daughter to both parents, 6; of son to father, 5; of son to mother, 4; and of son to both parents, 8.

The statistical technique basic to this study is called the Q technique, introduced by Stephenson (3) in 1935. In the early 1950s it was used fairly extensively in various psychiatric and psychological studies but gradually fell into desuetude, probably because of the mathematical effort involved in working out the correlation coefficients. However, the general availability of computers makes the Q technique an attractive way of developing information. In a number of studies we have found it to be consistently worthwhile as a form of automated psychiatric diagnosis. We believe it to have many other still unexploited uses for the psychiatrist.

[1]A table giving specific information on each of the subjects is available from the authors on request.

CONCLUSIONS

The high correlations of these offspring with their peers came as something of a surprise, but this finding is understandable on second thought. Certainly it seems to document objectively the popular notion of a generation gap. As far as the relation of offspring to parents is concerned, the offspring most often resembled a combination of both parents, then the parent of the same sex, and least often the parent of the opposite sex. Males resembled their mothers more than females resembled their fathers. Our results thus seem to confirm commonsense expectations.

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Indian Children and Tribal Group Homes: New Interpretations of the Whipper Man

BY JAMES H. SHORE, M.D., AND WILLIAM M. NICHOLLS, M.S.W.

The authors describe a community-based children's home and child welfare program among a tribe of Plateau Indians. The program has been effective because it is compatible with this Indian culture, which accepts extended family and community responsibility for child care. The authors feel that the program demonstrates principles of primary prevention in community mental health.

AN OLD CUSTOM among the Plateau Indians of the Pacific Northwest exemplified community responsibility for child care. The tradition concerned an individual called the Whipper Man, who was outside the immediate family. The Whipper Man was highly respected by the elders and the young. He was chosen by tribal leaders and relatives on the basis of development of character beyond reproach. The Whipper Man functioned in the role of disciplinarian. He punished youngsters if they were disrespectful to elders. This discipline was administered in a very positive sense and was understood by young and old. The whip he used hung over the door or on the wall of each home and was an omnipresent symbol reminding children that the Whip Man might be coming.

In July 1973 an Indian interpreter was asked to explain the development of the tribal child care program to a

Read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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general council meeting of a Plateau tribe from central Oregon. The interpreter explained that the new child care program was like going back to the old way, when there was a Whipper Man not connected with the immediate family who came and disciplined the children. The child care center was seen as taking up the Whipper Man's role in the village as a nonfamily participant in child-rearing practices who was sanctioned by the community. The general council, which is basically an open community meeting, voted overwhelmingly to approve the budget request for the child care program.

The new mental health program, developed within and supported by the Indian community, was seen as being compatible with ancient Indian tradition. It became part of a culture in which the responsibilities of the extended family and of the community were as important for child rearing as the immediate responsibilities of the nuclear family.

FOSTER PLACEMENT OF INDIAN CHILDREN

In a report of the Association on American Indian Affairs, Byler (1) commented extensively on the legal process that permits the placement of children declared neglected, delinquent, or abused in foster families or institutions. His main point was that this process causes the destruction of Indian families. He stated,

> A survey of states with large Indian populations ... indicates that 25–35% of all Indian children are removed from their families and placed in foster homes, adoptive homes, or institutions—and over recent years the problem has been getting worse .... Recognizing that in some instances it is necessary to remove children from their homes, [tribal leaders] argue that there are Indian families within the community that could provide excellent care. (1, pp. 1, 2)

In several Pacific Northwest Indian communities, 15 to 25 percent of the population under 18 years of age are not living with their natural parents. Many of these children are placed in a non-Indian foster home off the reservation.

A TRIBAL YOUTH HOME

After two years of extensive planning, the Plateau tribe from central Oregon opened a children's group home. This service had been developed under the supervision of the tribal council with mental health consultation from the Indian Health Service and support from other agencies. A child neglect committee of community participants had been functioning for several years with official tribal council endorsement and had established a precedent for community initiative in making decisions for the placement of Indian children.

At the time the group home opened, there were 219 Indian children under the age of 18 who were not living with their natural parents. These children were part of the total population of children under 18 years of age of approximately 800. The children in placement represented 28 percent of the total youth population. Of this number, 74 (34 percent) were in foster care with the state children's service agency, 47 (21 percent) were in boarding schools, and the remainder were in other off-reservation placements or tribal foster homes. Local homes were not licensed as foster homes and therefore received few if any services. Children were removed from their family homes because of complaints of neglect or abandonment. In 1971 and 1972 the numbers of Indian children placed under foster care were 40 and 30, respectively.

The tribal child care services were developed to include intensive outreach family counseling in addition to the group home for Indian children. The group home was designed to provide short-term sheltered care, long-term placement, counseling, and minor medical treatment for Indian children ranging from 1 to 18 years old. Staff for the group home and the outreach family counseling program were 90 percent Indian. In the first 12 months of operation, 246 Indian children from 135 families were placed in the facility. This represented 20 percent of all reservation families. The children ranged in age from 2½ weeks to 19 years. Problems related to excessive drinking by the parents accounted for greater than 90 percent of the placements. However, child abuse and the battered child syndrome were virtually unknown. Child behavior difficulties, such as juvenile delinquency and runaway reactions, as well as significant medical problems accounted for the remainder of the placements.

In the five years before the establishment of the tribal group home, a large number of Indian children under the age of 18 had been detained in the tribal jail for acts of delinquency. These children numbered 77 in 1967, 98 in 1968, 121 in 1969, 118 in 1970, and 120 in 1971. In one case the length of detention was 32 days. At least 25 percent of juvenile arrests were for a drinking violation. For many others, delinquent behavior was associated with the drinking problem of one or both parents. Although referrals to jail have continued since the opening of the tribal child care center, the average length of stay has been reduced to 1 day. Many children are referred immediately from the jail to the center; others bypass the jail entirely.

In our clinical experience on this and other Indian reservations, we have encountered a sense of hopelessness and despair in working with Indian parents about the problems of alcohol misuse and child neglect. Once placement of the children has been initiated, Indian parents often withdraw, become depressed, and begin or resume intensive drinking. This process is interpreted by the non-Indian outsider as further lack of concern for the children and as additional evidence of instability.

The development of a community resource where children can be adequately cared for in close proximity to their parents is an essential step in developing a program for better child care. This must be combined with an outreach program using Indian counselors to keep parents involved. The decision to place Indian children is made in our program by the Indian community. Due process is upheld through the tribal courts. If placement is necessary, the impact is minimized by a clearly stated policy of

returning children to their own families within a short period of time. Although some children may need off-reservation placement in individualized treatment plans, the initial success of the program is highlighted by a dramatic reduction of off-reservation referrals. Since the opening of the children's group home in January 1973, only one Indian child has been placed off the reservation in a non-Indian foster home. More Indian families have received outreach services before placement was indicated than were served before the home was established. Many families now receive services long before issues of custody or placement become important. Most children referred to the group home have been returned to their parents, who are receiving outpatient follow-up services. Some children have been placed in reservation-sponsored foster homes on the reservation.

DISCUSSION

We are beginning to see the development of child care programs under tribal sponsorship in other regions of the country. Plans for such programs are currently being made by the Wisseton-Wahpeton Sioux Tribe, the Rosebud Sioux Tribe, and the Oglala Sioux Tribe of South Dakota and by three affiliated tribes of the Fort Belnap Reservation in North Dakota (1). These tribes are developing comprehensive child welfare programs and tribal ordinances that will increase community control over the placement of Indian children. State agencies are also being asked to adapt state licensing standards to meet the expressed needs of Indian communities so that more American Indians can qualify as foster parents.

Since referral to an Indian boarding school is another method of responding to the pressure of Indian youth in crisis, it is not surprising that adjustment to boarding school is significantly affected by alcohol abuse. Of the 47 students referred to boarding school from our Oregon tribe in 1972, 28 were enrolled because of a problem with excessive drinking in a parent. There were 12 dropouts in this group. Seven students dropped out or were dismissed because of their own involvement with alcohol at school.

Swanson and associates (2) described the pattern of alcohol abuse in another tribal population of Indian children. They concluded that peer group pressure and a parental history of alcoholism were significant factors among Indian children with severe abuse patterns. Bergman and Goldstein (3) described the development of a model dormitory for Navaho boarding school students. Their program emphasized an increased staff-student ratio and development of sensitivity to the interpersonal needs of Indian children. Results clearly indicated that in such areas as intellectual, emotional, and physical development, the children in the model dormitory were significantly superior to those in the control dormitory.

Saslow and Harrover (4) discussed identity problems of American Indian children and concluded that effective educational programs must emphasize the development of adequate psychosocial adjustment. They described the school dropout phenomenon for Indian youngsters between the fourth and seventh grades, when a decline in academic achievement sets in. Bryde (5) reported personality differences between Indian and white students as indicated by the MMPI among the Oglala Sioux Tribe. He stated,

> Notable among the more meaningful variables [among the Indian students] were "feelings of rejection, depression, anxiety, and tendencies to withdrawal, plus social, self, and emotional alienation."

These feelings, which affect school adjustment, will not be changed through better education programs unless the cycle that disrupts Indian families is broken. Family stability is the essential link in constructing a chain of preventive adjustments. The children's group home and the family outreach program under tribal sponsorship is one approach that begins this process within the cultural values and political sanctions of the Indian community.

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LETTERS TO THE EDITOR

Confidentiality in the Military

SIR: As a psychiatrist currently serving in the Navy, I concur fully with the observation of Drs. Schuckit and Gunderson in "Suicide in the Naval Service" (December 1974 issue) that potentially suicidal servicemen need to be identified more often. The authors did not mention an obstacle to this process that is perhaps unique to the military, i.e., the complete lack of physician-patient confidentiality.

Every encounter a serviceman has with a physician is recorded in his health record. This record—and any psychiatric consultation it might contain—is available not only to his commanding officer but to promotion boards, ancillary health care personnel, clerical personnel, etc. Many servicemen believe that the mere presence of a psychiatric consultation in a man's record will result in lack of promotions, granting of less responsibility, increased scrutiny of performance, and other difficulties.

Compounding the problem is the fact that our cultural masculine role stereotype—that "real men" do not seek help, complain, or acknowledge emotional distress—exists in an intensified form in most military settings.

A serviceman exhibiting grossly disturbed behavior will virtually always be referred for psychiatric intervention, as will the troublesome individual with a character disorder, but deviation from the norm may not be seen in the depressed potentially suicidal individual.

One can readily postulate the existence of a subpopulation within the military which, because of the necessity of publicly acknowledging distress in order to obtain psychiatric help, chooses instead not to seek it. I feel that depressed individuals probably make up a significant percentage of this population.

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Editor's Note: The opinions expressed herein are those of the author and do not necessarily reflect the views or endorsement of the Department of the Navy.

Electroconvulsive Therapy in Patients with Parkinsonism

SIR: Psychiatric symptoms, particularly of depression, frequently accompany L-dopa therapy of Parkinson's disease (1) and occur also with administration of the adjuvant drug amantadine (2). These symptoms are generally reversible with a reduction or discontinuation of L-dopa or amantadine (3). Inasmuch as a review of the literature provided no references concerning the use, efficacy, and safety of electroconvulsive therapy (ECT) in treating psychotically depressed patients with Parkinson's disease, we wish to report the following case.

The patient, a 54-year-old woman with a documented 7-year history of Parkinson's disease, had been taking 4 to 5 g of L-dopa a day in divided doses for 4 years prior to her hospitalization, 100 mg of amantadine three times a day for 3 months, and 50 mg of diphenhydramine at bedtime for 1 week. Although she was described as having been depressed for years, she had recently begun having crying spells, developed insomnia, and become uncommunicative and anorectic (losing 20 pounds). Four days prior to admission she had become acutely paranoid and delusional, with auditory hallucinations, and had ingested 250 mg of diphenhydramine hydrochloride in an admitted suicide attempt. Physical examination on admission was consistent with Parkinson's disease; blood chemistries, hematology values, thyroid studies, serological test for syphilis, skull films, EEG, brain scan, and lumbar puncture (the patient had had a simple mastectomy for mammary carcinoma 5 years earlier) were normal.

Discontinuation of amantadine and diphenhydramine, reduction of L-dopa from 5 to 2 g a day, and institution of 100 mg of amitriptyline at bedtime resulted in no change in the patient's mental status or behavior. Consequently, over a 3-week period, seven ECT treatments (140-volt shocks of 2 seconds duration) were administered. Medications given intravenously during each treatment were .5 mg of atropine, 60 mg of sodium methohexital, and 50 mg of succinylcholine. All treatments resulted in well-modified seizures and were excellently tolerated by the patient. Mood, affect, appetite, and sleep pattern improved markedly; delusions, paranoid ideation, and hallucinations disappeared; and the patient became communicative, friendly, and cooperative. During the 3-week course of ECT, L-dopa was gradually increased to the previous level of 5 g a day in divided doses, with resultant good control of the patient's parkinsonism and no return of psychiatric symptomatology.

Although the etiology of her psychotic depression—whether drug-induced or endogenous and involutional—cannot be ascertained, ECT proved safe and effective in this patient with Parkinson's disease.

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Accuracy of Diagnosis and Genetic Factors in Schizophrenia

SIR: In his article "From Rationalization to Reason" (September 1974 issue), Seymour Kety, M.D., presented data to argue for the reliability of the diagnosis of schizophrenia and the presence of a "strong genetic component" in the etiology of schizophrenia. I believe that these data are subject to other interpretations.

Dr. Kety contends that the reliability of independent diagnosis of the major psychotic syndromes is reasonably high once a standard nosology has been agreed on. However, he cites no support for this proposition. The most relevant study, that of Beck and associates (1), contradicts his assertion. Moreover, Dr. Kety's own data—although too sketchy for detailed evaluation—suggest that the reliability of the diagnosis of schizophrenia is modest at best.

It appears from Dr. Kety's presentation that in only 7 of 24 cases in which one rater made a diagnosis of "definite" schizophrenia did the other raters concur, and in 17 of 41 cases in which at least one rater perceived schizophrenia, there was little agreement among all the raters.

I would suggest that Dr. Kety's overall ratings of the reliability of the diagnosis of schizophrenia would be significantly lower if schizoid and inadequate personalities were not included within the overall category of what he terms the "schizophrenia spectrum." Even if the diagnosis of schizophrenia were reasonably reliable under idealized conditions, its demonstrated unreliability in actual practice argues strongly against its use at this time for other than research purposes.

Dr. Kety presents two findings to support the conclusion that schizophrenia involves a strong genetic component. The first is that there is a higher incidence of schizophrenia in the biological relatives of schizophrenic adoptees (13.9 percent) than among their adoptive relatives (2.7 percent) and among all subjects not biologically related to them. However, not only is the incidence of schizophrenia among the biological relatives of schizophrenic adoptees too low to posit much of an influence of genetic factors in the etiology of schizophrenia (only 2.9 percent of the biological relatives were found to exhibit "chronic" schizophrenia; the other relatives' diagnoses were either "latent" [3.5 percent] or "uncertain" [7.5 percent] schizophrenia). As Dr. Kety himself recognizes, these data are fully compatible with a nongenetic hypothesis emphasizing such factors as birth trauma, in utero influences, and early mothering experiences. Moreover, how does one explain the development of schizophrenia in the great majority of adoptees whose biological relatives apparently exhibit no evidence of schizophrenia at all?

Dr. Kety is thus forced to rely on the finding that a higher percentage of paternal half-siblings of schizophrenic than of nonschizophrenic adoptees evidence schizophrenic pathology. Dr. Kety feels this finding excludes an early environmental interpretation because the paternal half-siblings did not share in utero influences and early mothering experiences with their adopted half-siblings—i.e., because they share only "the same father and a certain amount of genetic overlap." But sharing the same father generally means sharing the same socioeconomic conditions (which in turn affect in utero nutrition, etc.), sharing the same standards of child bearing, and in all probability sharing the same type of mothering, since the fathers—especially if they are disturbed—are likely to remarry women with similar psychodynamics. Thus, since the early environments of the half-siblings were probably far more similar than Dr. Kety recognized, the theory that schizophrenia has a strong genetic component remains, at best, a tenable hypothesis.

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THOMAS R. LITWACK, PH.D.
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Dr. Kety Replies

SIR: There was neither the time nor the justification to present in my address to the APA annual meeting or in my *Journal* article all of the data that my collaborators and I have been gathering over the past 10 years. The data I did present were very pertinent to the claims of Szasz, Laing, and Rosenhan, respectively, that schizophrenia is a myth, has no biological basis, and cannot be recognized consistently. Had I been able to present more data, Dr. Litwack might have been spared the necessity of making inferences, some of which were erroneous.

In our study, 365 people participated in a psychiatric interview in their homes. About 30 percent of these subjects were genetically related to a person who had been removed from their environment early in life and adopted by another family and who later became schizophrenic. Three raters read the interviews independently and blindly and made a diagnosis based on *DSM-II* (1). The study provided an opportunity to examine the validity of the traditional concept of schizophrenia, which we called "chronic schizophrenia" and which was similar to Kraepelin's description. Each rater made very few diagnoses of chronic schizophrenia in the sample (3, 6, and 5, respectively), as would be expected in a nonhospitalized population. If that syndrome were a myth, had no validity, or could not be recognized, the diagnosis would have occurred randomly. A coincidental agreement by three raters would be expected only once in more than 500,000 subjects. In our sample, the diagnosis was made by all three raters in 3 of the 365 subjects, yielding a chi-square value of over 12,000. Where there was disagreement on the diagnosis, the range of disagreement was small, and all raters agreed on the diagnosis of "definite schizophrenia."

The broader category of definite schizophrenia, which included "chronic" and "latent" schizophrenia and "acute schizophrenic reaction," was made by each rater in about 4 percent of the subjects. The coincidence of 3 such diagnoses would be expected only once in more than 15,000 subjects. All three of our raters made this diagnosis in 10 of the 365 subjects, yielding a chi-square of over 3,700. On the basis of either of these results, the dictum of Szasz and Rosenhan can be rejected with a confidence of more than 99.999 percent.

Dr. Litwack also raises the question of the reliability of psychiatric diagnosis. The concordance between pairs of raters on the diagnosis of definite schizophrenia in our study was 70 percent. In the study that he cites by Beck and associates, the paired agreement among psychiatrists for definite diagnoses in a psychiatric outpatient population was 81 percent, hardly an argument for unreliability of diagnosis, especially since neither population would be expected to contain mental illness as severe or as typical as that in a hospitalized population. Whether the reliability of psychiatric diagnosis is high enough for every purpose is a matter of opinion, but it has been sufficiently high to permit demonstration of the therapeutic efficacy of a substantial number of drugs and to guide the therapy of individual patients. Of course, I would not wish to defend the accuracy of diagnoses made by *all* psychiatrists—especially those who have been persuaded that psychiatric nosology is useless or spurious.

I did not suggest that we should be satisfied with reliability which is only reasonably good, or that diagnostic reliability cannot be improved. The very essence of the medical model requires constant sharpening and further characterization of the phenomenological syndromes, and I indicated that some of our studies may contribute to that end.

Turning to the evidence I cited for a strong genetic component in the etiology of schizophrenia, Dr. Litwack argues that an incidence of 13.9 percent (definite or uncertain) in the biolog-

ical relatives of schizophrenic adoptees is too low to posit much of an influence of genetic factors. If we had chosen index cases with phenylketonuria instead of schizophrenia, we would have found far fewer biological relatives to be affected. Even in a disorder like Huntington's chorea, with a dominant monogenic transmission, the expected incidence in the biological relatives represented in our sample would not exceed 30 percent. It is fallacious to think that the importance of genetic transmission in a disorder can be judged by the percentage of relatives affected. Incidentally, Dr. Litwack is wrong in inferring that the great majority of adoptees had no schizophrenia in their biological families—actually, more than half (17 of 33) did.

I cited the significantly higher incidence of schizophrenia in the biological paternal half-siblings of the schizophrenic adoptees as the most compelling evidence for genetic factors and as one reason for rejecting Laing's claim that schizophrenia has no biological basis. Dr. Litwack suggests that besides sharing the same father, they may have shared the same socioeconomic conditions, standards of child rearing, and type of mothering. Wender and associates (2) did not find any difference in socioeconomic class between the biological fathers of index and control adoptees. Also, Dr. Litwack assumes that the adoptee spent considerably more time with his biological mother than was actually the case: 7 of the 10 schizophrenic adoptees with schizophrenia among their biological paternal half-siblings remained with their biological mothers a month or less—most for only a week. An alternative hypothesis capable of explaining the findings on a nongenetic basis would have to assume an as yet unspecified environmental factor so powerful that such a short exposure would result in the development of schizophrenia 20 years later. It would also require that the biological father select his mates on that basis, and would have to explain why such a factor did not produce a considerably higher incidence of schizophrenia in the biological mothers' unadopted children, who were exposed to it for a greater part of their lives. We have not been able to construct such a hypothesis with even a modicum of plausibility.

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SEYMOUR S. KETY, M.D.
Boston, Mass.

Electroconvulsive Therapy and Language

SIR: I would like to report a case involving the effects of electroconvulsive therapy (ECT) on language. The patient, a 30-year-old woman who was born in France but has been living in this country for about 6 years, became severely depressed shortly after the birth of her second child. I was consulted after no improvement resulted from two weeks of treatment with tricyclic antidepressants. The patient was hospitalized and given amitriptyline hydrochloride (Elavil) and haloperidol (Haldol). It was decided to use ECT because of the depth of her depression. She was much improved after six treatments, but she became confused and disoriented and was kept in the hospital until her confusion subsided.

She was discharged on a regimen of 200 mg of amitriptyline hydrochloride a day. Several weeks later, both she and her husband complained that she was unable to speak English at times and that she often spoke French spontaneously. (Before her course of ECT, she did not speak French in her home or in her community.) When asked to speak English, she became agitated and tearful and appeared not to understand. This situation persisted for about two weeks and then disappeared. Throughout her short period of language difficulty she was alert and oriented, and there was no change in her personality. At present, she speaks only English, but she does remember speaking French at inappropriate times.

The diagnostic possibilities seem complicated, but I think that the ECT may have temporarily interfered with her receptive-expressive pathways, resulting in a return to her native language. I have heard from another psychiatrist of a similar case, but I have not seen this phenomenon described in the literature.

L.H. LIPSIUS, M.D.
Rome, Ga.

On Reporting Data Statistically

SIR: I found the article "The Tranylcypromine Isomers: A Controlled Clinical Trial" by Javier Escobar, M.D., and associates (September 1974 issue) very interesting and provocative. However, it is not clear in their presentation whether the therapeutic differences observed between the groups treated with the (+) and (–) tranylcypromine isomers were significant in the intuitive sense or in the statistical sense.

It would be extremely helpful if data presented in the *Journal* were always analyzed using statistical procedures if at all possible, with the results expressed in those terms.

This is not to imply that the observations reported in the article by Dr. Escobar and associates would not be worthy of publication if they were not statistically significant. Data of a highly suggestive nature may have considerable heuristic value even when the p value is greater than .05.

ROBERT O. FRIEDEL, M.D.
Seattle, Wash.

Dr. Escobar Replies

SIR: On the first page of our article, under the heading "Psychopathology," is the statement "The patients receiving the (–) isomer showed significantly greater improvement on all factors of the Hamilton Scale." By "significantly" we meant that there were statistically significant differences ($p<.05$ or better) favoring the (–) isomer over the (+) isomer at some point(s) during the rating period. On the Clinical Global Impressions at day 7, the patients receiving the (–) isomer showed a significant improvement ($p<.05$) over their scores at the baseline compared to those receiving the (+) isomer, who showed no significant improvement. The difference in improvement was statistically significant, favoring the (–) isomer ($p<.05$). On the Hamilton Depression Scale, there were also statistically significant differences in improvement always favoring the (–) isomer for all four factors: factor 1 (sleep disturbance), day 3 ($p<.05$); factor 2 (somatization), day 7 ($p<.05$); factor 3 (anxiety, depression), days 3 and 14 ($p<.05$); and factor 4 (apathy), day 8 ($p<.05$). On the Symptom Checklist 90, the only significant difference was on factor 6 (anger, hostility) at the posttreatment rating (day 21, $p<.05$), and this favored the (–) isomer.

Overall, the patients receiving the (–) isomer showed an improvement over baseline which was significantly greater than that of patients on the (+) isomer. The consistency of the find-

ings makes it unlikely that the pretreatment difference in pathology accounted for this greater improvement. Although it is unusual indeed to find statistically significant differences with samples as small as the one we used, both the statistical and clinical impressions were that the (–) isomer is the most effective and the more rapid in action of the two isomers and that its effectiveness across the full three weeks of the study would have been more evident if we could have continued increasing the dosage. As may be seen in figure 1 of our article, the major improvement observed for the (–) isomer occurred at week 1, when the maximum dose was reached. From then on, improvement was less dramatic, and the total score for the Hamilton Depression Scale tended to go up for patients on the (–) isomer. We are planning a double-blind study on a larger sample of patients using a higher dose of the isomers to further test the above points.

JAVIER I. ESCOBAR, M.D.
St. Paul, Minn.

Thyrotropin-Releasing Hormone as an Antidepressant

SIR: Many studies have reported an antidepressant effect of treatment with thyrotropin-releasing hormone (TRH) in depressed patients. An antipsychotic and energizing effect in schizophrenic patients and increased alertness and energy in normal subjects have also been reported. Coppen and associates (1) recently presented data refuting the antidepressant activity of TRH. My associates (E. Smeraldi, E. Sacchetti, G. Spoto, G. Tassi, and F. Mangiarotti) and I were intrigued by these contrasting results and decided to investigate the problem. We treated 6 patients aged 28 to 62 suffering from secondary depression with TRH, administered 4 times at 48-hour intervals. The first dose was 600 g, and the next three were 300 g. We wished to determine whether TRH has an antidepressant effect in secondary depression.

Thyroid-stimulating hormone (TSH), 3,5,3′-triiodothyronine (T_3), and 3,5,3′-tetraiodothyronine (T_4) were assayed before the rapid intravenous administration and then at intervals of 10, 20, 30, 60, and 90 minutes by radioimmunoassay.

TSH, T_4, and T_3 levels were normal before stimulation, excluding a pathology of the pituitary-thyroid axis related to the emotional disturbance. After the 600-g TRH stimulation, TSH secretion increased eight-fold, and with 300 g it increased by 300 to 500 percent, with a peak between 15 and 30 minutes. The increase of T_4 and T_3 was proportional to that of TSH. No psychological improvement was noted on either of two instruments used. Only minor and variable mood fluctuations were reported, and they could not be related to the treatment.

Thus in confirmation of the results of Coppen and associates, we can report that TRH does not display a significant psychological effect in secondary depression in patients with a normal hypothalamo-pituitary-thyroid function. We have no explanation for the previous reports of positive psychological influence other than the possibility that hormonal treatment has a psychological influence only when patients have a basic endocrine imbalance.

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Editor's Note: The author of this letter provided an extensive reference list, which we were unable to print due to space considerations. This list is available from the author on request.

Suggestions for Psychiatric Record Audit

SIR: Regarding the special section on peer review in the December 1974 issue, permit me to make some suggestions based on the premise that we need to document the quality of treatment of hospitalized patients. We must establish a psychiatric record audit committee in every hospital. This committee should be responsible for reviewing charts on a random basis to determine whether they contain the following information:

1. Documentation of the need for hospitalization.
2. History that contributes to the understanding of the patient's emotional problems.
3. Physical and psychological examinations.
4. A diagnosis that is logical in view of items 1 through 3.
5. A record of treatment.
6. Progress notes that amplify the treatment record and demonstrate the physician's day-to-day care of the patient.
7. Instructions to nursing personnel.
8. Consultations for conditions that are outside the expertise of the treating physician.
9. Appropriate plans for discharge.
10. The essentials of the in-hospital course at the time of discharge.

The committee would collect this information and use it for the following purposes:

1. Education of the staff.
2. Development and elevation of standards of care.
3. Dealing with auditors representing organizations outside of the hospital.
4. Setting the limits on physicians who are not prepared to document the care of their patients so that the adequacy of treatment can be validated.

MERVIN ROSENBERG, M.D.
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LETTERS TO THE EDITOR are welcomed and will be published, if found suitable, as space permits. Like other material submitted for publication, they must be typewritten double-spaced. The letters should not exceed 500 words, including references, unless a special arrangement has been made with the Editor, and they will be subject to the usual editing. Receipt of letters will not ordinarily be acknowledged.

New Mind, New Body. Bio-Feedback: New Directions for the Mind, *by Barbara Brown, Ph.D. New York, N.Y., Harper & Row, 1974, 454 pp., $9.95.*

Biofeedback is a generic term for a whole set of behaviorally derived treatment techniques now being used for migraine and tension headache, Raynaud's disease, insomnia, and, at least in early pioneering work, a range of other problems from asthma to epilepsy. For human patients these techniques appear to "work" clinically through the interaction of a combination of new specific autonomic learning (1) and nonspecific positive expectation (2, p. 27).

Biofeedback, a new concept plus a new technology, has opened up a whole frontier of possibilities in the applied use of autonomic operant conditioning. Further, it has great scientific significance in that it has shown the limitations of traditional theories of learning, which until recently held that operant conditioning could occur only with skeletal muscles.

To most of the basic scientists in this field, it seems perfectly plain that the multiplicity of clinical techniques that have already been evolved should be subjected to rigorous and comparative clinical testing, using appropriate controls.

As clinicians, many of us are a bit weary of evaluating the extravagant claims and sparse data of therapeutic fads like orthomolecular psychiatry (3). However, it seems that the need for skeptical scrutiny arises once again in the case of *New Mind, New Body*. The tone of this book is correctly characterized in the brief foreword by Hugh Downs as one of "unabashed awe . . . at the emerging shape of the thing that is being studied."

Even when the author herself turns specifically to the medical uses of biofeedback, confident zeal replaces any acknowledgment of the need for controlled clinical testing. She states,

> What can one expect from our new feedback techniques? It is *immediately apparent* that they can provide major assistance in a wide variety of medical ills . . . of the cardiovascular system, . . . the respiratory system, . . . and muscle systems . . . . *So it is with each body system* . . . [and with] *anxiety, fear, pain and depression, which are equally well relieved by biofeedback procedures* [italics mine].

Such fervor, when it replaces direct evidence, tends to produce resistance and skepticism rather than belief and zeal. This was my personal reaction, despite my own considerable and favorable clinical experience with biofeedback.

This book is very much Dr. Brown's own personal creation; it is full of her unfiltered enthusiasm and visions for biofeedback. It also contains a first-person account of the thoughts and associations she had during her early work with biofeedback and a description of her feelings on discovering and beginning to communicate with other scientists in other places working along similar lines.

She tells of her participation as one of six charter members in the formation of the Biofeedback Research Society in 1969. In the same freewheeling, highly subjective, and personal way, succeeding chapters of her book deal with feedback of skin potential responses (two chapters); muscle tension, single neuromuscular units, and heart rate (two chapters); and blood pressure and alpha waves (two chapters). One chapter on EEG feedback deals with learning to identify one's own brain waves—alpha versus beta versus theta patterns. The last two chapters are frankly speculative.

By self-proclamation, this is a book about "possibilities and expectations"; it is neither a scientific nor a clinical book. It is also not sufficiently objective or complete to be taken as either an adequate nontechnical overview of the field or an adequate historical account of the early scientific development of biofeedback. The book is hard to follow and is not chronologically organized, apparently because the author follows the flow of her own associations. In addition, its coverage is very spotty: there is relatively little in it about basic animal research on autonomic learning.

Still more strikingly omitted, especially since there are two full chapters on "Skin Talk," is the very early work of David Shapiro and his collaborators (4) on the operant reinforcement of human skin potential responses. There is no mention of the excellent work of Bernard Engel and associates (5) on cardiac arrhythmias, of Schwartz, Shapiro, and associates (6, 7) on hypertension, or of the exciting although still preliminary work of Sterman and associates (8, 9) on the use of biofeedback in the treatment of epilepsy.

To sum up, *New Mind, New Body* is an unfiltered, highly personal account of Barbara Brown's own thoughts and experiences as an early worker in biofeedback research and of her own hopes, wishes, and dreams for this field, which she obviously loves.

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Coping and Adaptation, *edited by George V. Coelho, David A. Hamburg, and John E. Adams. New York, N.Y., Basic Books, 1974, 440 pp., $17.50.*

For a long time it has been my contention that mental health is adequate maturity plus adjustment. For the adequately mature person, coping and adaptation are pretty much what living is all about; therefore, a book on this subject is more than welcome.

This volume is a follow-up of the Conference on Coping and Adaptation held in Palo Alto, Calif., March 20–22, 1969. The conference was sponsored by Stanford University's Department of Psychiatry and supported by NIMH. A group of top-notch people, leaders in their fields, have contributed to this multiauthor work on coping and adaptation, an excellent topic for interdisciplinary study.

Ecology, field studies of primates, ethology, ethnology, sociology, psychology, psychoanalysis, and political science are all represented in this volume. It is an attempt to further the unification of concepts from all of these fields. This alone is a great advance over the rivalry and even bitterness among the disciplines that have marred the history of studies in the behavioral sciences. Especially pleasing is the fact that the ideas presented here are based on biological theories of evolution stemming from Darwin and Wallace, even though evolution through natural selection is usually a process measured in hundreds of thousands if not millions of years.

All of the chapters are excellent. They are filled with data, well reasoned, broad, tolerant, and simply and clearly written. Especially interesting and illuminating are "Ethology, Ecology, and Ethnological Realities" by Goldschmidt, "Social Structure and Personal Adaptation: Some Neglected Dimensions" by Mechanic, White's "Strategies of Adaptation: An Attempt at Systematic Description," and two other exceedingly fine chapters, "Coping, Vulnerability, and Resilience in Childhood" by Murphy, and "Early Adolescence: A Specific and Stressful Stage of the Life Cycle" by Beatrix Hamburg.

Also stimulating and informative are the chapters "Coping with Long-Term Disability" by Adams and Lindemann, "Vigilance and Decision Making in Personal Crisis" by Janis, and "Adaptation to Stress in Political Decision Making: The Individual, Small Group, and Organizational Contexts" by George. These are followed by a thorough and informative section titled Assessment of Coping Functions. Lazarus, Averill, and Opton discuss the psychology of coping, French, Rodgers, and Cobb focus on person-environment fit, and Moos details psychological techniques in the assessment of maladaptive behavior.

The final chapter, by the editors of the volume, is a summary of the preceding contributions and is titled "Coping and Adaptation: Steps Toward a Synthesis of Biological and Social Perspectives."

Of course, such a synthesis is a hope and a goal to work toward rather than a fait accompli, but it is a noble, realistic, and necessary goal for mankind's well-being and, possibly, survival. Because of the state of each of the disciplines of the behavioral sciences, this collection is by necessity more a report of ongoing work and a clarification of concepts than a finished synthesis that is of practical value to the clinical psychiatrist. However, acquaintance with this body of work, theory, and thinking should be part of the education of every psychiatrist. To have it available in a single volume, and by such authorities, is a huge advantage and one not to be missed.

LEON J. SAUL, M.D.
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Rape: Victims of Crisis, *by Ann Wolbert Burgess, R.N., D.N.Sc., and Lynda Lytle Holmstrom, Ph.D. Bowie, Md., Robert J. Brady Co. (Prentice-Hall), 1974, 308 pp., $8.95; $5.95 (paper).*

Rape, as a psychological, physical, and social problem, has received more attention recently, partly because of the women's movement. This book is a valuable addition to the growing literature on women. It provides perspectives on rape from numerous sources, discusses the various community programs specifically designed to deal with the problem of rape, and presents information advocated by community groups on how to avoid becoming a victim. The book also details the concept of crisis and draws attention to techniques of counseling rape victims.

In the first sections, the view of and reaction to rape focus the discussion. The authors present a typology of sexual victimization developed by analyzing 146 women admitted to a hospital with the complaint of rape or sexual assault. The data, interspersed with verbatim comments from the rape victims, are categorized according to whether the victim consented. Three groupings emerge from this categorization—rape or sex without consent, accessory-to-sex or inability to consent, and sex-stress situation or sex with initial consent.

The authors also present the rapist's view by incorporating clinical observations drawn from research conducted at the Massachusetts Correctional Institution. These data establish four clinical classifications regarding motivation of the rapist. Although these are helpful in developing a profile of the aggressor, they lack the richness found in the interview data collected from the victims.

Perhaps the single most important aspect of this book can be found in the chapter that focuses on the rape trauma syndrome. The determination of two stages of this syndrome—the immediate or acute stage, during which the rape victim experiences lifestyle disruption, and the long-term process, when the victim must reorganize the disruption—provide insightful data and implications for counseling rape victims.

Additional data deal with the problem of the child and adolescent victim and the family's reaction to rape. The discussion presented in the book moves from a focus on those directly involved in the rape to the victim's family and larger community. Specifically, the authors describe the investigation of a rape complaint by the police, the victim's response to police, the problems police officers have identified in working on rape cases, and the recommendations of the District of Columbia Task Force on Rape. The discussion of the community's reaction to rape takes into account medical procedures and the psychological reactions of the victim at initial interview. The book offers suggestions for hospital staff dealing with this population.

Within the framework of crisis theory, the authors report on the immediate needs of the rape victim. Five categories of crisis requests were identified from the victim sample: police intervention, medical intervention, psychological intervention, control, and uncertainty. The importance of the initial interview, already stressed in the psychiatric literature, is especially pertinent in the situation of rape victims. This importance leads to a discussion of both the expected interview content and the interview techniques useful to those counseling rape victims. Counseling under a variety of circumstances and in a variety of settings receives major attention here.

An especially important aspect of this book lies in the material on the court process and its many ramifications vis-à-vis the rape victim. This information will be useful for health professionals who are subpoenaed by helping them to understand the court process and perhaps preventing them from making mis-

takes when testifying. The book supplies a glossary of appropriate legal and psychological terms, but it does not offer any suggestions as to further reading. This may reflect the state of knowledge on this topic.

As the victims of rape emerge from a confused web of taboos, guilt, shame, and additional victimizing by social forces, more of these women will seek assistance in dealing with the physical, psychological, social, and legal aspects of their situation. This book, an outgrowth of the fact that little exists in the way of counseling services or scholarly research on the problems that rape victims experience, is a basic and useful step toward correcting the lack of material on the topic of rape.

ANNE J. DAVIS, R.N., PH.D.
San Francisco, Calif.

Understanding Causality, *by Jean Piaget, with R. Garcia, translated by Donald and Marguerite Miles. New York, N.Y., W.W. Norton & Co., 1974, 185 pp., $10.00.*

In his previous rich and productive works, Prof. Piaget has studied the development of the cognitive processes by which a child comes to understand the world. He has described the progression of stages of thought from the preoperational sensorimotor processes of the infant and young child and the organization of these multisensory percepts into mental structures (schemata). Further, he has demonstrated how these sense-derived building blocks become related and enable the latency-age child to understand the world via the literal and semiscientific processes of concrete mental operations. Finally, he has described the development of powerful deductive and hypothetical mental abilities of adolescence into formal, logical mental operations. Although slow to be appreciated in the United States, his work has become regarded as an extremely productive source of concepts for child psychiatry.

As many readers are aware, Piaget is not simply a student of children who is content with an inside-the-head focus. Rather, he follows the tradition of the Western scientist-philosopher who finds it necessary to study children and the development of their thought in order to understand reality. Piaget attempts to study the relations between inside and outside—between developing mental operations and the events, objects, and forces that constitute the world. Questions of causality are of central importance in this mix of complex interactions.

Understanding Causality mainly reports on some 100 experiments that Piaget and his coworkers have carried out to elucidate the stages by which children understand such basic natural phenomena as the following: "transmissions of movements, problems of directions, composition of forces, sufficient reason, states of matter, exchange of heat." Each of these experiments presented children with a natural event and asked for an explanation. Why is it that only the end marble rolls away when a row of marbles is hit? What is happening when a cube of sugar is placed in a glass of water? Why does ice change to water and then to steam? Why does a yo-yo or a Slinky behave as it does?

These are intriguing questions; they allow Piaget to demonstrate the development of children's understanding of physical phenomena. He illustrates that conceptual development is not a straight-line progression dependent upon either maturation of the central nervous system or the type of experience. Rather, as one would expect, it is a variable mix. For example, regarding the composition of matter, the young child is able to understand the behavior of a sugar cube in water by invoking a corpuscular theory well in advance of being able to use this theory generally because he is able to see the sugar dissolve. Thus valid and logical concepts and explanations coexist with animistic, magical, prescientific logic throughout all of childhood.

The book would be enormously valuable for clinicians if it were possible to relate Piaget's findings to the mental functioning of disturbed children and adults. However, to the best of my knowledge, except for the promising starts by E.J. Anthony and E.H. Auerswald, such work has not been done.

In sum, *Understanding Causality* is an important book as well as a difficult and specialized book. The clinical psychiatrist will find it both fascinating and frustrating because of its simultaneous closeness to crucial aspects of mental functioning and its distance from immediate clinical application. For others, such as child development researchers and teachers, it is likely to be both important and useful. For those interested in the history of natural science, this should be an absolutely marvelous book for comparing the developmental stages of children's ideas about matter, force, and other aspects of classical physics with the historical development of such concepts. Finally, the book contains a 45-page, highly specialized discussion of epistemology and physics that I do not have the knowledge to comment on.

WILLIAM M. BOLMAN, M.D.
Honolulu, Hawaii

Images of Hope: Imagination as Healer of the Hopeless, *by William F. Lynch, S.J. Notre Dame, Ind., University of Notre Dame Press, 1974, 319 pp., $2.95 (paper).*

Dr. Leslie Farber sets the tone of this book by assuring the reader in the introduction that Father Lynch does not equate hope with optimism and happy endings and does not present hope as the only alternative to "our pervasive pessimism."

Furthermore, this book hopes to remedy one of the deficiencies in the mental sciences, namely, a deficiency in the psychology of hope. A cursory review of the literature reveals that hope or a sense of hopefulness has been dealt with by only a few writers, among whom are Lewin (1), French (2), Mower (3), Frank (4), Karl Menninger (5, 6), and Stotland (7).

Father Lynch defines hope as an arduous search for future good that is realistically possible but not yet visible. He states that hope is the very heart and center of the human being. However, he adds, hope must be tied to imagination, for the nature of hope is to imagine what has not yet come to pass but is still possible.

As Martin Buber put it, "Hope imagines the real," thus distinguishing this form of imagining from the unreal absorption of daydream and fantasy, whose objects are transient and solitary self-aggrandizement. Lynch also states that it takes more than one to imagine—that hope cannot be achieved alone.

The fuel for hope is wishing, which includes imagination, mutuality, judgment, and passion—in short, a joining of all that is human in a move toward what is not yet but could be.

Lynch goes on to say that the greatest hope of those who are sick is the knowledge that there is nothing wrong with them that is not human and is not present in some degree in everyone. In other words, it is the hope of the sick, and of the medical community, that they are curable; this hope makes the cure possible.

Father Lynch also talks about building a "city of man," a human city, as opposed to a "city of absolutism," a walled city from which various pockets of our humanity will always be excluded. The city of absolutism often poses as the ideal city, but it excludes imagination, racial groups other than one's own, the sick, and the deficient.

These two cities explain the secondary subject of this book,

which is a study of the human and the absolute in mental illness. It is the author's contention that one of the great hopes of all mankind is to be human and belong to the "city of man."

Finally, the author presents a supplementary text encompassing many of those writers and analysts who have handled in some way the ideas he presents on the human imagination and the absolutizing part of man.

This is really a fantastic book by a fantastic author. Dr. Farber perhaps describes Father Lynch best in the following statement:

> While he is learned enough about the literature my field [psychiatry] has accumulated during its brief history, scholarship alone cannot account for his remarkable effectiveness in this volume. So I must begin with a statement which because of its simplicity is difficult to make cleanly: Father Lynch is genuinely devoted to our calling. In fact, I suspect he is more devoted than many of its practitioners who tend understandably to be more quickly discouraged by its deficiencies. In these days of fashionable get-togethers between religion and psychiatry, I am impelled to add that he has no wish to proselytize or be prosetlytized. In other words, he is that rarest of human beings—the outsider who can speak as a friend.

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GEORGE A. CONSTANT, M.D.
Victoria, Tex.

Eugenic Sterilization, *compiled and edited by Jonas Robitscher, J.D., M.D. Springfield, Ill., Charles C Thomas, 1973, 116 pp., $7.95.*

Eugenic sterilization is defined in this book as improvement in the quality of a population by means of controlling childbearing on the basis of eugenic principles. Considered a biomedical intervention similar to other enforced therapies such as ECT, chemotherapy, biogenetic engineering, and organ transplantation, eugenic sterilization has moral, philosophical, political, legal, and social implications—all of which are controversial. It is not a treatment administered lightly by a physician whose motto is *primum non nocere*, "first of all, do no harm."

Dr. Robitscher, the editor of this series of essays on various facets of eugenic sterilization, credits the inception of his work to a consultation with a colleague from Pennsylvania who sought advice on the question of sterilizing a mentally defective young girl who "might become promiscuous."

Dr. Robitscher's research indicated the absence of any Pennsylvania statute authorizing such a procedure and disclosed the fact that 27 states have involuntary sterilization laws. In 21 of these states, the procedure is limited either to residents of specifically named institutions for the retarded or to institutionalized patients. Robitscher's preliminary research indicated that there is only a scattered and outdated body of literature on eugenic sterilization; there is no single comprehensive work in the area. His interest increased and prompted him to organize a program on the topic of eugenic sterilization at a joint meeting of the medical and psychiatric societies of Pennsylvania.

This volume is a collection of nine papers by the participants in this meeting. As such, it is a somewhat uneven but nonetheless fascinating compendium of current thinking on eugenic sterilization. It presents many, although not all, points of view on this subject. The writers represent the points of view of attorneys, Catholics, non-Catholics, blacks, whites, retardation specialists, psychiatrists, child psychiatrists, men, and women.

Scientist and humanist air their views on eugenic sterilization and, coincidentally, a host of other topics, including genetics, the nature/nurture controversy, informed consent, fitness of parenthood, population control, and voluntary sterilization. Although these topics only touch upon the subject of eugenic sterilization tangentially, their inclusion contributes to the richness of this slim volume.

Of special interest is the chapter by Donald Giannella on eugenic sterilization and the law. Prof. Giannella reviews the pertinent cases beginning with *Buck v. Bell* (1), in which the Supreme Court upheld the constitutionality of a Virginia law providing for the compulsory sterilization of mental defectives. After first discussing the legality of voluntary sterilization of competent adults, Giannella goes on to discuss situations in which sterilization is performed on legally incompetent patients in the absence of statutory law. He finally touches upon the question of the constitutionality of all statutes that provide for the sterilization of mental retardates and defectives who are not competent to legally consent to such sterilization. He concludes by suggesting that lawyers and psychiatrists work together to devise standard procedures for determining how and when mental retardates can arrive at decisions for sterilization that meet at least minimum standards of voluntariness.

This text can and should serve as a model for summarizing contemporary thoughts on any number of other controversial topics that suggest the need for putting some sort of perspective on the rights of the individual vis-à-vis the rights of society. Opposing viewpoints are clearly and concisely presented and are treated equally. The editor draws no conclusions. The reader is left to draw his own, if he can. In any event, the book suggests that one give careful thought to stimulating, and frequently conflicting, ideas.

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ELISSA P. BENEDEK, M.D.
Ann Arbor, Mich.

The Integration of a Child Into a Social World, *edited by Martin P.M. Richards. New York, N.Y., Cambridge University Press, 1974, 308 pp., $15.50; $4.95 (paper).*

The purpose of this collection of works is to define what the authors call a "new look" in developmental studies of children. Quite frankly, I do not share the editor's conviction of a new "dawning," but I did find the articles fascinating as well as informative, particularly as they reflect research areas in social psychology in England.

Unfortunately, there is no particular order to the 14 articles, all of which deal with some aspect of developmental psychology. Such a potpourri does not lend itself to general statements, but a discussion of some of the articles will give the reader an idea of the subjects discussed.

John and Elizabeth Newson of the Child Development Research Unit of the University of Nottingham explore the various cultural aspects of child rearing in the English-speaking world. These authors provide an excellent overview of the subject with an easy literary style that one might wish more authors would use to enliven their studies. Other articles include "Belief and Reality: Social Factors in Pregnancy and Childbirth" by Jane Hubert, "First Steps in Becoming Social" by Martin P.M. Richards, "The Conditions for a Social Psychology of Childhood" by Rom Harre, and "Ethnology and Early Socialisation" by N.G. Burton Jones.

It seems that the world of the child—in terms of those who make it their area of study—grows more complex and that there is further blurring of disciplines. The "new look" presented in this book is an amalgam of developmental psychology, anthropology, sociology, and philosophy—a heady mixture indeed, but nevertheless one worth reading.

JOHN C. DUFFY, M.D.
Governors Island, N.Y.

The Synaptic Organization of the Brain: An Introduction, *by Gordon M. Shepherd, M.D., D.Phil. New York, N.Y., Oxford University Press, 1974, 351 pp., $7.95; $4.95 (paper).*

A review of the neurophysiologic research during the past decade indicates that there has been a conspicuously rapid advance in our knowledge of basic mechanisms at a cellular level. However, this advance has not been without its costs in relevancy to the organism as a whole and behavior processes in general. Thus the cult of cellular microphysiology has largely failed to shed light on overall functional mechanisms. The idea is that now that we know the wiring diagram of the cerebellum, its function is obvious.

Yet the truth is that when the student of functional organization considers modern concepts concerning the function of the cerebellum, he does not find himself greatly in advance of the ideas propounded by the grandfathers of cerebellar physiology at the turn of the century. Thus studies of unit potentials, because they are largely divorced from the real world of functional relevance, may well result in the system physiologist's asking, "Where is it all getting us?"

Dr. Shepherd has provided us with a scholarly approach to the subject of synaptic organization. Those Sherringtonions among us who still regard the synapse as a simple junction for the transmission of an impulse between neurons will be both surprised and humbled at the enormous complexity that this subject now encompasses. Using his talents of clear and lucid exposition, Shepherd takes us on a voyage of exploration of synaptical organization as it is exemplified in regions of the brain that have been extensively studied. This includes the spinal cord, olfactory bulb, thalamus, cerebellum, hippocampus, retina, and neocortex.

Using the microelectric concepts of Rall and combining electron microscopy with cellular neurophysiology, Shepherd covers a highly complex area of scientific endeavor. It is surprising to find the degree to which quantitation of circuit constants, rate processes, etc., has been possible in this area during the last decade. Shepherd arranges his material with care and insight and has provided a series of diagrams of synaptic mechanisms that make the subject understandable, palatable, and often exciting. There is no doubt that the book will be extremely useful to the graduate student in neuroscience whose job it is to understand the comparative synaptology presented in this book.

However, the book is disappointing when it comes to implications concerning overall functions. There is virtually no reference to behavioral mechanisms that might be reflected in the wiring diagrams that are presented. Shepherd also fails to provide any real hints as to why the various radical departures in synaptic structure would be useful in the programming of overt functions. One could also be disappointed that Shepherd has not attempted to develop neurochemical concepts and relationships to neuropharmacology that might have reduced the isolation from function and behavior that is characteristic of his presentation.

Thus, regretably, the book cannot be recommended to the neurologist, the psychiatrist, or the clinician because the effort required to understand the concepts would not be reflected in better understanding of the behavioral problems associated with health and disease. They will have to await the passage of another decade, while today's neurophysiologists fill the gap between structure, function, and behavior.

REGINALD G. BICKFORD, M.B., B.CHIR.
La Jolla, Calif.

Therapeutic Effectiveness of Methadone Maintenance Programs in the Management of Drug Dependence of Morphine Type in the USA, *by Stephen S. Wilmarth and Avram Goldstein. Geneva, Switzerland, World Health Organization, 1974, 53 pp., 17 Swiss francs (paper).*

This succinct monograph reviews the data on therapeutic effectiveness of methadone in three selected programs, the methadone maintenance treatment program of New York City, the drug abuse program of Illinois, and the Santa Clara County, Calif., methadone program. The 19 pages of text, 114 references, 19 tables, and 12 figures provide a solid foundation for anyone entering the field as well as a refreshing overview for those who have been dealing with addicts for so long that their perspective has been clouded. If one were to select a single publication with which to introduce people to methadone treatment, I believe this would be it.

It is unfortunate that regulations for methadone treatment programs essentially rule out certain types of very important research. For example, how useful is it to require urinalysis? What measurable differences occur when psychotherapy is required compared with when it is not required? For what type of patients is psychotherapy essential and for what type is it a waste of resources? Because of their frequent contacts with patients, methadone maintenance programs provide treatment populations that have been unexplored for the testing of psychotherapeutic and health economics theories.

PAUL H. BLACHLY, M.D.
Portland, Ore.

Dynamics of Racism in Social Work Practice, *edited by James A. Goodman, Ph.D. Washington, D.C., National Association of Social Workers, 1973, 375 pp., $6.50 (paper).*

Dr. Goodman succinctly describes the purpose of this volume in his preface: to report on the effects of institutional racism on therapeutic intervention. Articles by both black and white au-

thors representing several mental health disciplines have been selected and organized into five sections: The Setting, Treatment, Community Organization, Education, and Research.

As might be anticipated, the articles in the first section focus on accounts of observations, some of which are historical, of racism embedded in the various institutions of our society and reflected by individuals in the various health professions. Since I have long been interested in psychiatric training, the conclusions drawn by Clemmont Vontress in an article first published in 1971 were of particular interest to me:

> [There is a] . . . need for a careful look at approaches to training therapeutic professionals. Presently, counselors are not being trained to work effectively with counselors of African descent. Basic to such training should be a curriculum designed to help would-be counselors understand the implications—psychological, physical and economic—of being black in a white society.

The 18 articles grouped in the second part of the book, titled Treatment, point up the resistances and nontherapeutic interpretations that are rooted in racism and its sequelae.

Several treatment modalities, including individual psychotherapy, group therapy, and psychoanalysis, are considered. A number of illustrations are highlighted to prompt the reader to study the material in depth. Shirley Cooper cites several clinical illustrations in which "white guilt" in the therapist generated a sharp decrease in clinical objectivity. Carter and Haizlip provide a look at the transference and countertransference reactions in biracial treatment with a black therapist, a white patient, and a white supervisor. Their contribution is especially important in light of the fact that greater efforts are being made to increase the pool of minority mental health professionals.

A number of thoughtful suggestions are made toward resolution of the identified problems. Sager, Brayboy, and Waxenberg, in their article "Black Patient—White Therapist," call for a reappraisal of current therapeutic programs for the poor. They state,

> Methods of engagement that are more deeply rooted in the patient's world, and that reflect his priorities rather than the therapist's, need to be developed.

Petro and French, reporting from the Midwest, discuss a staff development project with the identified goals of "raising the level of sensitivity to and understanding of clients' experiences as black persons." Another study, reported by Graff, Kenig, and Radoff, yields data that negate several stereotypes about lower-class patients.

In my opinion, racist attitudes in the psychoanalyst and/or the editors and publishers of this book are showing in "An Interracial Analysis: Transference and Countertransference Significance." Throughout this article, written by a white analyst, the word "Negro" is spelled with a lowercase "n." However, the author does admit to countertransference problems that relate to the racial difference and writes of his efforts to "understand the meaning of his inappropriate behavior." Therapists would do well to heed his thesis:

> The racial difference between analyst and analysand involves issues of unconscious meaning at many levels, and there are serious hazards in either overestimating or in ignoring the interracial factor.

Five articles comprise the section titled Community Organization. Proposed actions include instituting classes to provide for conjoint learning for students and community residents and reorienting the practice of social work to conform to the needs and directions of minority groups. Contributors to this section also provide a historical summary of events that triggered the black communities' initiating proposals for programs to meet needs identified by community residents.

Current educational practices are reviewed in the section on education. Proposals geared toward the eradication of racism are offered for curriculum change and for strategies for faculty and student changes.

Three research studies are presented in the final section. One deals with a program designed to modify the traditional function of lower-echelon staff on a psychiatric unit; the other two studies evaluate the effects of attitudes of service-givers.

Throughout the volume, evidence is presented that traditional mental health services as well as the philosophy on which they are based warrant modifications if the poor and minority groups are to receive meaningful services. However, this is not to suggest that these groups are homogeneous and that none of them can benefit from traditional treatment modalities.

Although this book is written primarily for those in the field of social work, it is a valuable addition to the libraries of other mental health professionals and could be used beneficially in training programs.

JEANNE SPURLOCK, M.D.
Washington, D.C.

The Psychology of Human Ageing, *2nd ed., by D.B. Bromley. Baltimore, Md., Penguin Books, 1974, 416 pp., $2.95 (paper).*

Any book that has in its title the term "psychology" can be assured of some popularity and a fairly good volume of sales. The shelves of bookstores are filled with psychological treatises covering almost every phase of human existence. I equate the term "psychology" with the "systematic knowledge and investigation of the phenomena of consciousness and behavior" (according to the second edition of *Webster's New International Dictionary*). Dr. Bromley's book has more than this to offer. I would be more at ease if his title were different.

Theories, concepts, deductions, and pseudoscientific evaluations all have their place in the investigatory process, but to draw valid conclusions from this type of material rather than from scientific fact leads to conclusions that are more conceptual than factual. However, in this book much of the material is factual, comprehensive, and enlightening, although it is peppered here and there with dynamisms. Chapters 2, 4, 5, and 10 are worth the price of the entire volume. The methodological issues and the charts as well as the topics of psychopathology, psychometrics, and psychiatry are better left to textbooks focusing on these areas.

The author outlines the history of human aging from Sumaria and ancient Egypt. The hieroglyphics from the tomb of Ptah-ketep are fascinating and interesting elements in the development of human history. The philosophy of the times is well outlined, and the story of Hardedef is truly a gem of history.

We are guided through the history of aging in Greece, ancient Rome, and the Islamic culture as well as during the Middle Ages. Galen, Avicenna, Maimonides, and others are considered from the point of view of their contributions to the concepts of aging. The ideas of Shakespeare and Francis Bacon are deftly woven into the story, and attention is called to their writings dealing with diet, conduct, and heredity. Gradually we are taken into the nineteenth and twentieth centuries and the discoveries of Lister, Pasteur, and Metchnikov. Unfortunately, in this con-

nection the problem of legal responsibility, which is such an important issue today, is only touched upon.

A chapter on the political and economic history of the aged, including a discussion of England's Poor Law Amendment Act of 1843, brings one right up to the present attitude toward old age. Here the author concludes that "it becomes increasingly apparent that the processes of ageing are complicated and must be studied in a variety of ways." Social reforms, including health and welfare provisions for the elderly, will increase in size and momentum, giving rise eventually to various political forms of the present-day welfare state.

The author undertook a monumental task. It seems to me that the chapters on psychometrics, statistics, and nosology of the various types of mental disorder, including schizophrenia, would be better left to textbooks on psychiatry. However, the book is well organized, the subject matter is vast, and the author's concepts are clearly presented.

Although Bromley for the most part deals with the situation as it applies to England, much of the material can be applied to the United States. To students of sociology and psychology and to the physician, it will give delightful reading as well as an understanding of the problems of the senior citizen that concern most of us today. For the layman, the chapters mentioned above are comprehensive, enlightening, and extremely helpful.

ISADORE GREEN, M.D.
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The Psychology of Depression: Contemporary Theory and Research, *edited by Raymond J. Friedman and Martin M. Katz. Washington, D.C., V.H. Winston & Sons (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 301 pp., no price listed.*

The deep-rooted, unshakable analytic concept that depression is nothing but hostility turned inward is now, according to several of the writers in this book, only a disproven theory. "Science" has now shown that hostility and depression are separate entities. It seems that truth is only in the mind of the believer.

Instead of the supposedly discarded maxim concerning depression, Aaron T. Beck proposes his cognitive theory that it is the depressed patient's distorted evaluations which produce depression. According to Beck, a psychic trauma such as the death of a loved one, if "construed as a subtraction from the individual's personal domain," may trigger a depression. (The emphasis is on the word "construed.") From this concept stems the obvious conclusion: one achieves improvement in a depressed patient "by pinpointing the patient's specific cognitive distortions and demonstrating their invalidity to the patient."

In the technical language of psychology, C.B. Ferster finds that "the common denominator among depressed persons is the decreased frequency of many kinds of positively reinforced activity." He states that the more depressed a person is, the greater the distortion of his perceptions and therefore the fewer the situations of positive reinforcement.

Research on man is difficult—he is a stubborn animal, willful and difficult to experiment with. He is subject to too many variables and lives too long to be a good guinea pig. However, Martin T. Seligman has come up with an intriguing analog for man's depression in animals—the state he calls learned helplessness. In response to a shock from which it cannot escape, an animal becomes passive, its learning retards, it develops anorexia, and it loses weight. This condition is self-limiting, and the level of epinephrine in the whole brain is decreased.

In principle, the animal develops these symptoms because it has lost control over the trauma; it cannot escape it and therefore develops a learned helplessness. By analogy, the depressed patient has developed a state of learned helplessness; he believes that he cannot control the events of his life that will relieve his suffering and provide him gratification.

Seligman's therapy consists of forcibly exposing the animal to activities that enable it to escape from the trauma and reward it for the effort. He physically pulls the helpless dog away from the shock areas until the dog "learns" to motivate itself. In a similar fashion, both Beck and Ferster find that if patients can be persuaded to perform acts that are rewarding, the rewards themselves will be therapeutic in overcoming their helplessness.

Each of the 22 panelists represented in this collection of articles has his own theory. To Klerman, depression serves a signal function, i.e., the patient is saying, "I need help." To Lewisohn, a low rate of response-contingent positive reinforcement is a stimulus for depression. To. I.C. Kaufman, all depressions—whatever their cause—have what he terms an organismic basis. Schmale sees a distinction between helplessness and hopelessness and differing responses to each.

Spiro writes that more studies need to be made on life histories and social structures. He relates interesting sidelights on children in Israel and monks in Burma. Friedman notes that depressions should be described in three separate categories: normal affect, clinical depression, and a depressive character style. Chodoff explains the analytic concept of depression as follows:

> Depression-prone people are . . . dependent on narcissistic supplies derived directly or indirectly from other people for the maintenance of self-esteem.

The biochemical basis for depression is dealt with tersely but well in this volume: Frederick Goodman brings us up-to-date in few but pithy sentences.

Because so little is known about depression, much is said. The serious student of depression, if he is to maintain his intellectual honesty, must concede that his own pet theory is still a theory. In all objectivity, he must restrain his tendency to reject what he feels are outlandish ideas. Some of the "outlandish notions" in this volume, although contrary to one's cherished belief, are worth examining for their mind-expanding qualities.

SAMUEL H. KRAINES, M.D.
Chicago, Ill.

Humane Reproduction. Report 86, *by the Group for the Advancement of Psychiatry. New York, N.Y., GAP, 1973, 113 pp., $4.00 (paper).*

The tone of this sensible, pragmatic book is set on the first page by a quotation from Freud newly translated by Stephen Fleck, the chairman of the GAP committee that prepared the report. Fleck's translation reads,

> It cannot be denied that Malthusian concerns become a necessity in married life at some time or other. Theoretically it would be one of the greatest triumphs of mankind, one of the most compassionate liberations from natural bondage to which we are subject, were it possible to raise the responsible act of procreation to a level of voluntary and intentional behavior, and to free this act from its entanglement with our indispensable satisfaction of a natural desire.

This book addresses itself to "the need for humane reproduction in adjusting a nation to fulfillment of the capacities of its citizens and their communities" (p. 394). The authors believe that preventing unwanted children and unwanted parenthood does more to prevent emotional illness than any other single measure.

In following their thesis, the authors do not derogate the family as a functioning unit. Rather, they stress that the family's psychological value for both children and parents is diminished when procreation is not planned. They point to the fact that it is late in the day to persist in the assumption that no matter how many children we produce, they will somehow be taken care of and somehow flourish. They underline the fact that the increase of the number of human beings on earth has become one of the major crises facing man today. They illustrate what services and information are available for rational reproduction and give brief information on such matters as abortion consultation and contraceptive services.

They emphasize that the family is a psychosocially essential system, but they point to the specific disadvantages for children of large families—the ills of parental and social rejection. The changing role of women, especially the changes that have occurred in career opportunities for women, highlight a change in attitudes. The authors plead for services in neighborhood health centers to provide planned and restrained reproduction; they also advocate education for an informed "humane parenthood."

This book is a brave attempt to point to the benefits of planned reproduction, an approach that is likely to evoke less bitter controversy than the abortion dilemma. The authors are to be congratulated on their endeavor.

R. BRUCE SLOANE, M.D.
Los Angeles, Calif.

Children's Experience with Death, *by Rose Zeligs, Ed.D. Springfield, Ill., Charles C Thomas, 1974, 239 pp., $10.75.*

Books on the topic of death are proliferating at an increasing pace. It is incongruous to envisage death as a bandwagon, but this is what it seems likely to become. An editorial in the *Journal of the American Medical Association* titled "Dying Is Worked to Death" (1) pointed out the "extraordinary influx of essays, editorials, even books and specialized journals, on the subject of death and dying."

How can this current preoccupation be accounted for in view of the fact that death and dying have been always with us? Is it due perhaps to the waning influence of religious beliefs and the terrifying prospect of nothingness or to the pervasive dread of a nuclear holocaust?

The preoccupation with death is nothing new. Art and literature have been portraying death for centuries, frequently in horrifying detail. What is new is a sensitivity to the physical and psychological rights of the dying. We are beginning to ask ourselves whether it is their right to know that they are dying and is it their right to die with dignity without being compelled to undergo distressing prolongations.

The attempt to give the physician some understanding of the psychology of the dying individual so that he can be of some help to the patient rather than an embarrassed bystander is also new. Recent publications have focused on this facet of death; Dr. Zeligs' book provides a good example. It reviews the now familiar literature, furnishing some vivid vignettes of children talking about death, learning about death, and experiencing death. It also looks closely at the child's response to the loss of a parent and adds a final chapter on the supports afforded by religion. Its tone is humanistic; however, it adds nothing to what we already know. That is the point: do we need more of this?

In his editorial Dr. Vaisrub (1) made the following critical statement:

> It is much too easy to write about death. There is no need for statistical evidence and for lengthy references. . . . Perhaps because it is so easy to write about dying, so much is written about it without saying anything new.

This is unfortunately very true. The anecdotes change, but the references, the speculations, the theories, and the advice remain remarkably the same.

This book is well written, lucidly presented, and adequately documented for its purpose. It touches on only a small part of the burgeoning literature; this is on the positive side since it makes no pretentions to being an encyclopedia. It is probably best suited for nurses, clergymen, and medical students.

The author makes several telling points that should be kept in mind by those who come in contact with dying children: that they are caring for a living child as long as he is alive, that there should be no whispering whatsoever in the presence of the dying child, and that the sickroom can be made an extension of the home where the family are all together. These axioms cannot be reiterated often enough if we want to do the best we can for the child in extremis.

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E. JAMES ANTHONY, M.D.
St. Louis, Mo.

Child Personality and Psychopathology: Current Topics, vol. 1, *edited by Anthony Davids, Ph.D. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 236 pp., $13.95.*

In his contribution to this volume, "Changes of Direction with Psychotic Children," Eric Schopler very aptly states,

> Since the clinician's role includes turning knowledge into practice, the absence of adequate information may be experienced as guilt.

This statement sums up much of my compulsive reading.

This new series, titled *Child Personality and Psychopathology*, promises to provide timely knowledge on a regular basis. Volume 1, which fulfills this promise, is divided into two parts. The first deals with personality development and disorders and has three excellent reviews of problems that are extremely timely.

In chapter 1, Henry Biller deals with paternal deprivation, cognitive functioning, and the feminized classroom. His review of the concept of paternal deprivation is excellent, and the material he presents on paternal influences and cognitive function is fresh. Biller evaluates Sexton's major work on the feminized classroom (1) in a very objective way; he also includes an excellent reference list.

Chapter 2 deals with the relation of learning in childhood to psychopathology and depression in young adulthood. Eron, Lefkowitz, Walder, and Huesmann continue the work they reported in 1960, which demonstrated a positive relationship be-

tween certain parental disciplinary practices in middle childhood and aggressive behavior exhibited by children in school. The study reported in this book deals with the original population, following the children from third grade, when they were 8 years old, until they reached 18 years of age. The material presented tends to support the predictions made by these authors. This paper is excellently written and provides a model for research.

There have been quite a few reviews of childhood school phobias, but I have not seen any review recently that so well explores our current knowledge of this problem as Miller, Barrett, and Hampe's chapter 3, "Phobias of Childhood in a Pre-Scientific Era."

The second part of the book has three papers that deal with childhood psychosis. Bernard Rimland's paper, "Infantile Autism, Status and Research," is a must to read because it covers the diagnostic checklist as well as behavioral and biological approaches to childhood psychosis.

Long and Lovaas' paper, "Research and Treatment with Autistic Children in a Program of Behavior Therapy," provides an excellent summary of their work with 20 children for the past 10 years. They conclude that behavioral changes lapse without continued reinforcement and that parents must be used as continuing treating agents.

Eric Schopler's paper, "Changes of Direction with Psychotic Children," speaks most clearly to the front-line psychiatrist in all of us. He offers hope where there is despair and some very specific treatment plans in his developmental therapy approach.

REFERENCE

1. Sexton PC: The Feminized Male: Classrooms, White Collars, and the Decline of Manliness. New York, Random House, 1969

BARRY GRUNDLAND, M.D.
Napa, Calif.

Clinical Notes on Group-Analytic Psychotherapy, *by D. Wilfred Abse, M.D., B.Sc., D.P.M. Charlottesville, Va., University Press of Virginia, 1974, 182 pp., $6.50.*

This well-written book, organized into four basic parts, seems easy enough to read, but the task of understanding it is another matter.

Group therapy is an important method by which psychiatric care is delivered to people who have in common the quest for the relief of suffering. Group-analytic therapy is concerned with the treatment of psychoneurotic patients. It is especially concerned with those who are the victims of character neuroses that impair their interpersonal relations and lead to loneliness, withdrawal, feelings of failure, and general dissatisfaction or periodic depression.

The first part of this text deals with basic principles and practical considerations and applications of group-analytic psychotherapy. In this kind of psychotherapy the interaction of group members, which initiates the therapeutic process, is promoted. The therapist observes and deals with the same forces in the group situation as in individual analysis—unconscious drives, conscious reactions, and adaptation to reality. Dr. Abse clearly defines the overlapping phases that occur in the group-analytic process; he is constantly aware of the transference and countertransference problems incurred in such a complex transaction. The need for a great sense of objectivity and a tremendous ability for flexibility on the part of the leader is implied throughout the text.

The book is filled with very useful nuggets of information and insights particularly helpful to those who work in this field. However, to really understand this text one needs to have a theoretical and practical base in psychoanalysis as well as experience in treating groups. Dr. Abse contrasts group-analytic psychotherapy with individual psychoanalysis both clinically and theoretically. He also compares group-analytic psychotherapy with other forms of group therapy, such as family therapy, multiple therapy, encounter groups, and Gestalt therapy.

The second part of this book deals with group psychology and group psychopathology. One timely section is dedicated to the basic understanding of leadership in terms of charisma and political power.

In part 3 Dr. Abse devotes four chapters to life, theater, and therapy. Part 4, Innovations and Comparisons, deals with the comparison of group-analytic therapy with other forms of group therapy. Dr. Abse puts these all in perspective.

The book's bibliography is excellent. The majority of important contributors to the theory and clinical understanding of group work are included.

The pitfalls and flaws of treatment and training are constantly pointed out throughout the book. If one were to consider starting such a group without having had a psychoanalytic base, it is likely that the group therapy would quickly degenerate into something other than what was originally intended. For those with the proper background, this type of treatment would be of inestimable use in resolving transference resistances and other forms of resistance that might not be worked out in individual therapy.

I highly recommend this text to those who are working in group-analytic therapy. For those who intend to, it is a must. The insights, warnings, suggestions, and concepts can save endless hours of pain, suffering, and turmoil in working with these groups.

BARNEY M. DLIN, M.D.
Philadelphia, Pa.

Clinical Psychology: Expanding Horizons, *2nd ed., by Norman D. Sundberg, Leona E. Tyler, and Julian R. Taplin. New York, N.Y., Appleton-Century-Crofts, Meredith Corp. (Englewood Cliffs, N.J., Prentice-Hall, distributor), 1973, 624 pp., $11.95.*

A decade has passed since the first edition of this book was published. During those 10 years the field of clinical psychology has continued to evolve, to take clearer shape, and to separate more definitively from the science of psychology. The authors carefully minimize the actual separation of the "art of clinical psychology" from the mainstream of scientific psychology. They repeatedly emphasize the importance of scientific training, an experimental foundation, familiarity with statistical analysis, and the basic value of continued interest in research. This emphasis may have been acceptable 10 years ago, but it is not the measure to which clinical psychologists continue to march.

It is unfortunate that the authors give no indication of their own professional affiliations. They even refrain from using any degree designations. All we are told is that two of the authors are connected with the University of Oregon, presumably in the psychology department of that institution.

The authors define the role of the clinical psychologist as three-fold—assessment, therapy, and research. Just as the practicing clinical psychologist typically devotes his time and effort largely to therapy, so the book devotes most of its pages to the matter of therapy. The disproportionate amount of space given

to therapy has its advantage, however, because the book is addressed primarily to students of psychology who may be considering clinical psychology as their subspecialty. The image comes through with clarity.

The book is generally well written and makes an easily readable text. The settings, clients, and activities of the psychologist form a highly complex system to consider and explain; however, to abbreviate the system by referring to "SCAs" does not add to the reader's comprehension.

"Diagnosis" and "therapy" are terms that suggest the medical model, an item that seems to cause the authors continuing consternation. It is referred to repeatedly from the preface to the last chapter. Diagnosis becomes the "gathering and processing of information." Therapy becomes "the improvement program." The authors state, "Psychology has now moved so far beyond the medical model that it is undesirable to use those restrictive terms" (p. 136).

The clinical psychologist, according to the authors, should not work with a psychotic person unless he is in close association with a physician. Unless the psychologist knows something about diagnosis, how does he decide whether a patient is psychotic? The distinctions made between counseling and therapy in chapter 13 find the psychologist again associated with medicine because the authors accept the designations of "patient" in therapy and "client" in counseling. The matter of the psychiatrist-psychologist relationship is discussed very openly in chapter 19. That discussion should have been sufficient.

The section on interviewing and the section on testing are highlights of the book. There is a valuable discussion of encounter groups in which the authors make some important value judgments. The section on community psychology is also an asset to the book. In contrast, the chapter on psychobiological systems is weak and shows some inaccuracies. Like other good clinical psychologists, the authors might have benefited from some medical consultation.

ROBERT J. MCALLISTER, PH.D., M.D.
Grants Pass, Ore.

Phenothiazines and Structurally Related Drugs. Advances in Biochemical Psychopharmacology, vol. 9, *edited by Irene S. Forrest, Ph.D., C. Jelleff Carr, Ph.D., and Earl Usdin, Ph.D. New York, N.Y., Raven Press, 1974, 804 pp., $35.00.*

This volume summarizes the proceedings of the Third International Symposium on Phenothiazines and Related Compounds, which was held in June 1973. The proceedings are impressive and indicate our continued advances in the knowledge of the phenothiazines from the point of view of their chemistry, pharmacology, and clinical effects. Not only are the phenothiazines discussed, but related compounds such as the thioxanthenes are mentioned.

Anyone interested in this class of compounds should surely scan this volume. It is organized into a series of sections similar to the sessions at the symposium. These include Physical Chemical Aspects and Methodology, Mode of Action and Metabolism, Side Effects, Chlorpromazine Metabolism, Distribution and Excretion Including Assay Procedures, Metabolism, Thioxanthenes, Specific Chlorpromazine Metabolites, Pharmacologic Effects of Phenothiazines and Related Drugs, Phenothiazine Effects on Macromolecules and Neurotransmitters, Round Table Conference on the Relevance of New Basic Data to Clinical Parameters, and Final Summary.

Almost all of the outstanding investigators in this field were invited to the conference. Thus the papers included in this book represent a veritable *Who's Who* in the field. The book is an invaluable source of information of special interest to chemists and pharmacologists. It is also of interest to clinical psychopharmacologists and psychiatrists concerned with the research aspects of antipsychotics. All medical and pharmacy libraries should obtain copies. The editors and symposium organizers are to be congratulated for a job well done.

EDWARD F. DOMINO, M.D.
Ann Arbor, Mich.

Schizophrenia: The Meanings of Madness, *by Alexander R.K. Mitchell, M.B., Ch.B. New York, N.Y., Taplinger Publishing Co., 1974, 153 pp., $6.50.*

This short book is definitely written for the layman and paraprofessional in training as a text on the understanding of schizophrenia. The book deals with the problems of diagnosis, research, and treatment in a concise college outline form. There are few references to the original authors in each of these areas. The use of this text will not bring the psychiatrist or psychiatrically sophisticated layman up-to-date on schizophrenia; newer concepts in the research and treatment of this disease are not taken up.

As to conveying to the reader the personal and familial agonies that schizophrenia entails, the author does an adequate job, but this book is not as good on this subject as Rosenbaum's text, titled *The Meaning of Madness* (1).

In short, I cannot recommend this text as an up-to-date treatise or review of schizophrenia or as a detailed description of madness (see, for contrast, *Chronic Schizophrenia* by Freeman and associates [2]). However, I can recommend it as a primer for the layman, who will find in it clear definitions and an openness regarding the many unknowns in the research for the etiology of schizophrenia and the understanding of madness.

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1. Rosenbaum CP: The Meaning of Madness: Symptomatology, Sociology, Biology and Therapy of the Schizophrenias. New York, Science House, 1970
2. Freeman T, Cameron J, McGhie A: Chronic Schizophrenia. New York, International Universities Press, 1958

JAMES R. STABENAU, M.D.
Farmington, Conn.

Homosexuality: A Changing Picture, *edited by Dr. Hendrik M. Ruitenbeek. New York, N.Y., Humanities Press (U.S. distributor), 1973, 218 pp., $7.50.*

This book consists of a series of articles written by different authors, some of whom are known to be homosexual or closely identified with homophile groups. The principal theme of many chapters is that homosexuality is an alternative lifestyle; those who look upon it as a pattern of maladjustment are therefore more in need of psychiatric treatment than is the homosexual.

Psychiatry and religion are attacked as the sources of the problems of homosexuals. Statements such as "It is not homosexuality which is pathological—it is the entire discipline of psychiatry" and "Psychiatry is taken strongly to task as not only an adversary but the arch enemy" are but part of a well-planned assault on psychiatry and religion.

Inspired by the success of militant black groups in activating

group guilt to such a degree that many churches paid substantial sums of money to indemnify black people, militant homosexuals began an assault on psychiatry. They invaded and disrupted meetings where homosexuality was to be discussed and held demonstrations. Because most psychiatrists have neglected this problem, a capitulation to the demands of the militant homophile groups was initiated.

Changes in community attitudes have been accomplished in this age of sexual revolution. It is now recognized that all homosexuals are not exhibitionistic, that they are not aggressive psychopaths, and that they can be contributing members of society. Restrictive laws are being changed and substantial improvement in the concern of the individual has been brought about.

Despite these changes, this book recognizes the fact that a proportion of those with a homosexual adjustment are dissatisfied and seek psychiatric care. The growing literature on the successful reversal of sexual patterns will contribute to even better understanding of this problem as well as provide ways to prevent it.

SAMUEL B. HADDEN, M.D.
Wynnewood, Pa.

APA Grant Program for Minority-Group Medical Students and Residents

A small number of qualified minority applicants (including but not limited to American Indians, Asian Americans, black Americans, and Spanish-speaking Americans) will receive residency stipends, assistance in selecting a residency program, expenses to a yearly meeting with other minority fellows to share experiences and administrative help through APA's Office of Minority Affairs. The program is sponsored by APA, with funds provided by the National Institute of Mental Health.

Applications are being accepted now for residencies beginning in July 1976 and subsequent years. Applicants must be U.S. citizens and must have graduated from a U.S. medical school or possess the ECFMG certificate.

For further information write Jeanne Spurlock, M.D., Office of Minority Affairs, American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009, or call (202) 232-7878.

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Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

Medical, Moral and Legal Issues in Mental Health Care, *edited by Frank J. Ayd, Jr., M.D. Baltimore, Md., Williams & Wilkins Co., 1974, 210 pp., $13.50.*

La Relaxation Thérapeutique chez l'Enfant, *by Jean Bergès and Marika Bounes. Paris, France, Masson et Cie, 1974, 191 pp., 50 French francs (paper).*

Introduction to Rehabilitation Research, *by Brian Bolton. Springfield, Ill., Charles C Thomas, 1974, 191 pp., $14.50.*

How to Help Your Child Get the Most Out of School, *by Stella Chess, M.D., with Jane Whitbread. Garden City, N.Y., Doubleday & Co., 1974, 292 pp., $7.95.*

The Optimal Personality: An Empirical and Theoretical Analysis, *by Richard W. Coan. New York, N.Y., Columbia University Press, 1974, 235 pp., $12.00.*

Legacies in the Study of Behavior: The Wisdom and Experience of Many, *edited by Joseph Warren Cullen. Springfield, Ill., Charles C Thomas, 1974, 268 pp., $17.50.*

Pain, *by Dr. Arthur S. Freese. Baltimore, Md., Penguin Books, 1975, 242 pp., $2.25 (paper).*

The Promiscuous Teenager, *by Daniel T. Gianturco, M.D., and Harmon L. Smith, B.D., Ph.D. Springfield, Ill., Charles C Thomas, 1974, 97 pp., $8.50.*

The First Year of Bereavement, *by Ira O. Glick, Robert S. Weiss, and C. Murray Parkes. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1974, 305 pp., $12.50.*

Awareness Experiences for School Use, *by Bette Hamlin. Dayton, Ohio, Pflaum Publishing, 1975, 73 pp., $3.95 (paper).*

Creative Divorce Through Social and Psychological Approaches, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1975, 172 pp., $12.95.*

Modification of Behavior of the Mentally Ill, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 223 pp., $13.50.*

Problems of Adolescents: Social and Psychological Approaches, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 271 pp., $14.75.*

Prolactin 1974, *by Dr. D.F. Horrobin. Lancaster, England, Medical and Technical Publishing Co. (Montreal, Canada, Eden Press, distributor), 1974, 152 pp., $15.00.*

Prolactin: Physiology and Clinical Significance, *by David F. Horrobin, M.A., D.Phil., B.M., B.Ch. Lancaster, England, Medical and Technical Publishing Co. (Montreal, Canada, Eden Press, distributor), 1973, 236 pp., $18.00.*

Developmental Psychology, *4th ed., by Elizabeth B. Hurlock. New York, N.Y., McGraw-Hill Book Co., 1975, 368 pp., $11.95.*

These Are My Sisters: A Journal from the Inside of Insanity, *by Lara Jefferson. Garden City, N.Y., Anchor Press/Doubleday, 1975, 196 pp., $2.50 (paper).*

Alcoholism: A Medical Profile. Proceedings of the First International Medical Conference on Alcoholism, *edited by Neil Kessel, Ann Hawker, and Herbert Chalke. London, England, B. Edsall & Co., 1974, 200 pp., $16.00.*

Progress in Psychiatric Drug Treatment, *edited by Donald F. Klein, M.D., and Rachel Gittelman-Klein, Ph.D. New York, N.Y., Brunner/Mazel, 1975, 1,115 pp., $31.50.*

Successful Aging, *by Olga Knopf, M.D. New York, N.Y., Viking Press, 1975, 222 pp., $8.95.*

Supplement I. A Bibliography of Books on Death, Bereavement, Loss and Grief: 1968–1972, *compiled by Austin H. Kutscher, Jr., Martin Kutscher, and Austin H. Kutscher. New York, N.Y., Health Sciences Publishing Corp., 1974, 62 pp., $4.95 (paper).*

Masked Depression, *edited by Stanley Lesse, M.D., Med.Sc.D. New York, N.Y., Jason Aronson, 1975, 367 pp., $12.50.*

A Physiological Basis for Personality Traits: A New Theory of Personality, *by David Lester, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 124 pp., $9.75.*

Integrated Psychiatric Treatment, *by Julian Lieb, M.B., B.Ch., and Andrew Edmund Slaby, M.D., M.P.H. Hagerstown, Md., Medical Department, Harper & Row, 1975, 185 pp., $9.75 (paper).*

Explorations in Psychohistory: The Wellfleet Papers, *edited by Robert Jay Lifton with Eric Olson. New York, N.Y., Simon and Schuster, 1974, 359 pp., $9.95; $3.95 (paper).*

Understanding Homosexuality: Its Biological and Psychological Bases, *edited by Dr. J.A. Loraine. New York, N.Y., American Elsevier Publishing Co., 1974, 214 pp., $15.95.*

Early Child Care in Switzerland. International Monograph Se-

ries on Early Child Care 2, *by Kurt K. Lüscher, Verena Ritter, and Peter Gross. New York, N.Y., Gordon and Breach, 1973, 122 pp., $9.50.*

The Pleasure Bond: A New Look at Sexuality and Commitment, *by William H. Masters and Virginia E. Johnson, in association with Robert J. Levin. Boston, Mass., Little, Brown and Co., 1975, 268 pp., $8.95.*

Rehabilitive Kardiologie: Dosiertes Training und Leistungsmessung, *edited by H. Mellerowicz, J. Weidener, and E. Jokl. New York, N.Y., S. Karger, 1974, 173 pp., $35.75.*

Biological Mechanisms of Schizophrenia and Schizophrenia-Like Psychoses, *edited by Hisatoshi Mitsuda, M.D., D.Med.Sci., and Tetsuo Fukuda, M.D., D.Med.Sci. Tokyo, Japan, Igaku Shoin, 1974, 329 pp., no price listed.*

Student Personnel Work in General Education: A Humanistic Approach, *edited by Harold A. Moses. Springfield, Ill., Charles C Thomas, 1974, 386 pp., $16.75.*

Woman's Work: The Housewife, Past and Present, *by Ann Oakley. New York, N.Y., Pantheon Books (Random House), 1974, 268 pp., $8.95.*

Role Behavior and Role Conception in a Therapeutic Community: Construction of an Observational Device for Evaluation of Occurred Changes with the Participants, *by Hanna Oren-Huppert. Amsterdam, The Netherlands, Swets & Zeitlinger, 1974, 135 pp., 28.50 Dutch guilders (paper).*

Coordination of Services for the Mentally Handicapped: An Account of a King's Fund Research Project, *by Leslie Paine, M.A. London, England, King Edward's Hospital Fund for London, 1974, 44 pp., £1.50 (paper).*

The EEG in Acute Cerebral Anoxia: Assessment of Cerebral Function and Prognosis in Patients Resuscitated After Cardiorespiratory Arrest, *by Pamela F. Prior. Amsterdam, The Netherlands, Excerpta Medica, 1973, 314 pp., $36.95.*

Emergency Psychiatric Care: The Management of Mental Health Crises, *edited by H.L.P. Resnik, M.D., and Harvey L. Ruben, M.D., M.P.H., with Diane Daskal Ruben, M.A.T., J.D. Bowie, Md., Charles Press (Robert J. Brady Co.), 1975, 170 pp., $8.95 (paper).*

Group Psychotherapy from the Southwest, *edited by Max Rosenbaum. New York, N.Y., Gordon and Breach, 1974, 126 pp., $10.00.*

Psychiatric Assessment by Speech and Hearing Behavior, *edited by Clyde L. Rousey, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 365 pp., $18.75.*

The Depressive Spectrum, *by Dean Schuyler, M.D. New York, N.Y., Jason Aronson, 1974, 171 pp., $10.00.*

The Child/Adolescent and Urban Psychiatric Clinics, *by Jerome S. Silverman, M.D. New York, N.Y., Health Sciences Publishing Corp., 1974, 181 pp., $7.95 (paper).*

Counseling Couples in Groups: A Manual for Improving Troubled Relationships, *by Robert L. Smith, Ed.D., and Ann M. Alexander, M.Ed. Springfield, Ill., Charles C Thomas, 1974, 95 pp., $8.75.*

Medicaid: Lessons for National Health Insurance, *edited by Allen D. Spiegel, Ph.D., and Simon Podair, M.A. Rockville, Md., Aspen Systems Corp., 1975, 356 pp., $24.00.*

Careers of the Criminally Insane: Excessive Social Control of Deviance, *by Henry J. Steadman and Joseph J. Cocozza. Lexington, Mass., Lexington Books (D.C. Heath and Co.), 1974, 198 pp., $14.00.*

Adjustment to Widowhood and Some Related Problems: A Selective and Annotative Bibliography, *by Cécile Strugnell. New York, N.Y., Health Sciences Publishing Corp., 1974, 201 pp., $6.50 (paper).*

The Adolescent in Group and Family Therapy, *edited by Max Sugar, M.D. New York, N.Y., Brunner/Mazel, 1975, 282 pp., $13.50.*

An Arranged Marriage, *by Inge Trachtenberg. New York, N.Y., W.W. Norton & Co., 1975, 272 pp., $6.95.*

Detection of Dependence-Producing Drugs in Body Fluids. Report of a WHO Meeting of Investigators. Technical Report Series 556, *by the World Health Organization. Geneva, Switzerland, WHO (Albany, N.Y., Q Corp., distributor), 1974, 50 pp., 5 Swiss francs (paper).*

Process and Practice in Family Therapy, *by Gerald H. Zuk, Ph.D. Haverford, Pa., Psychiatry and Behavioral Science Books, 1974, 120 pp., $9.75 (paper).*

OFFICIAL ACTIONS

Fall Committee Meetings

Following is a summary of the proceedings of the fall committee meetings of the American Psychiatric Association, which were held in Washington, D.C., in October 1974.

The Council on Medical Education and Career Development

ALBERT J. SILVERMAN, M.D., CHAIRMAN

THIS COUNCIL MET formally in March, May, and October 1974, and a meeting was scheduled for March 1975. Components met in October 1974, with some additional meetings held by certain committees. In general, conference calls were encouraged. The reorganization of the Council structure was accomplished by October 1974. Reports of Council actions and responses of the Reference Committee and Board of Trustees follow.

The Council met on March 7, 1974, at Point Clear, Ala. Dr. Silverman reported on the meeting of the *Steering Committee for the Working Conference on Psychiatric Education* held February 28 to March 2, 1974. Some concern was expressed at the lack of a relationship with this Council as well as with other APA working groups. A tentative schedule aiming for commission work between March and June 1974, the Conference in June 1975, and publication of the conference report in February 1976 was formulated.

Drs. Feldman and Senescu reported on the meeting on recertification held in Houston, March 1 and 2, 1974. This led to recommendation that APA make a formal statement about this issue and how to use the self-assessment test. The *Committee on Continuing Education* was so directed. The Council also recommended improved liaison with the American Board of Psychiatry and Neurology via meetings with APA-appointed Board members and the Council.

The Council, having received material expressing concern about the lack of teaching of ethics, recommended that material already collected by APA in this area be sent to the Assembly, professors of psychiatry, and the directors of training progrms. The Council further recommended that the teaching of ethics be included in the forthcoming Conference on Psychiatric Education.

The Council had received material concerning sex clinics and licensing counselors and hypnotists. Because these clinics and practitioners represent a new and burgeoning issue, the Council recommended that the matter be referred to the Council on Emerging Issues.

Dr. Kaplan presented his report of the *Committee on Medical Education.* The *Task Force To Plan a Conference for Family Life Education* has not yet secured outside funding. The Council directed Dr. Kaplan to communicate with the chairman of the task force, Arnold M. Kallen, M.D., for additional data. Because behavioral science teaching appeared to be in disarray, it was suggested that the committee establish liaison with the Behavioral Science Committee of the National Board of Medical Examiners (NBME) and that a behavioral scientist be invited to meet with the committee to help develop national standards. The Council endorsed these recommendations.

Dr. Coppolillo's report on the *Committee on Graduate Education* was in the form of a letter since he was unable to be present. In considering the Liaison Committee on Graduate Medical Education of the Coordinating Council on Medical Education, the committee expressed concern over the appeal mechanisms and indicated more information was needed. The committee was asked to be in touch with the appropriate bodies and develop this information.

In considering the internless residency, the committee recommended a more medically oriented first year even if the overall program required a fourth year. The American Board of Psychiatry and Neurology (ABPN) has issued a recommendation regarding a four-year program in which the equivalent of one year would be spent in "medical" learning. All the members of the Council expressed themselves as in favor of this, but some concern was expressed regarding its financial feasibility. The Council endorsed the committee's position but expressed concern regarding the immediate feasibility of a change to a four-year program. The Council also expressed concern over the lack of interaction with the ABPN on these issues as well as our ignorance of the data that led to the recommendation. This was underscored by the fact that the Council had been attempting to

collect data to determine the results of several years of the internless residency. The committee accepted the recommendation that a Task Force in Administrative Psychiatry (curricular matters) not be endorsed at this time.

No new report was available from the *Task Force on Research Training.* The manuscript on the monograph on school mental health consultation from the *Task Force on School Consultation* is expected shortly. A discussion followed regarding data which demonstrated that a very low percentage of board-eligible individuals in psychiatry, in contrast to other specialties, actually get certified. This question was referred to the Committee on Continuing Education.

The *Committee on Continuing Education*, Robert A. Senescu, M.D., chairman, reported that more development of subcommittees is necessary. Dr. Senescu is chairman of the ad hoc committee, which met on March 5, 1974, assigned to work on the self-assessment test. The Council agreed with the recommendation from the Committee on Continuing Education that all their functions, including the self-assessment test, be under its advisory mission. Thus the new ad hoc committee should be under the Committee on Continuing Education. In discussing recertification, the committee recommended and the Council agreed that its previously approved statement should be republished in *Psychiatric News* and elsewhere for wide distribution. Staff will arrange for this.

The question of APA support of an Office of Education was discussed. The questions of funding, the range of concerns, and the relationship to the NBME, to the ABPN, and to other specialties and organizations were extensive enough so that it was felt that an additional meeting was necessary to effect closure on this issue. This was scheduled for May 20, 1974.

The report from the *Commission on History* outlined its activities since the October 1973 meeting, a continuation of work on the "Syllabus of the History of Psychiatry." Letters have gone out to department chairpersons requesting their help in recording oral memoirs of leading psychiatrists. Roche Laboratories is sponsoring the *Benjamin Rush Lectureship on Psychiatric History* at the annual meeting this year. Some commission members expressed concern about a communication gap in the establishment of a task force on psychohistory in another council. Staff will look into this and attempt to facilitate liaison.

A written report from the *Commission on Certification in Administrative Psychiatry* was received. An updated reading list has been sent to the 22 candidates who will be examined in May 1974 (the largest group ever) and to the 6 candidates on a waiting list. In view of the commission's work with other organizations to plan a curriculum in administration, Dr. Barton, in a recent letter to Dr. Foley, stated the question of offering examinations through the ABPN would be reopened. In considering the possibilities of alternative funding for psychiatric education, the Council recommended a combined loan with forgiveness for service plus timed repayment including teaching costs.

The *Committee on Liaison with the American College of Physicians* has been transferred to the Committee on Continuing Education. The "Liaison Group with the American College of Physicians" was suggested as a name. The two major topics of the meeting on May 20, 1974, at the APA central office were the relationship of the Council to the ABPN (especially concerning the problem of the internship year) and a proposal for an Office of Education within the APA staff structure. To introduce the subject of the relationship between the Council and the ABPN, Dr. Pat McKegney, chairman of the Department of Psychiatry at the University of Vermont, summarized a report from the American Association of Chairmen of Departments of Psychiatry that listed various problems related to internship, residency, and matching plans. It proposed a short-term solution—to live with the dicta of the ABPN—but also raised some long-term questions about residency training: where it should be carried out, by whom, for whom, and for what period of time.

It was felt that the efforts of many individuals in this field are currently becoming focused and that this Council should relate to the Association of American Medical Colleges (AAMC), the directors of residency training programs, the professors, and others. The possibility of using joint data banks in order to avoid discrepancies in calculations was mentioned.

A previous statement of this Council had suggested that the reinstitution of the internship was desirable, but concern was expressed about its feasibility at this time. The Council had suggested that there should be time for the ABPN to study the internship. The Council approved the concept that there should be either an internship or a four-year term for the study of psychiatry and that this should be implemented in 1977.

Dr. Feldman reported that the ABPN has not yet taken action concerning recertification and expressed concern about those in APA who have never taken board examinations. The Council again pointed out the need for better liaison with the ABPN. A recommendation was made that a liaison group between the Council and the ABPN be established, and this was accomplished. Drs. Senescu and Shader were appointed to serve as liaison from the Council to the ABPN at the latter's policy meeting in Chicago on July 12 and 13. It was also felt that there should be a liaison between the ABPN and the Council similar to the one that had previously existed with the Committee on Medical Education.

The remainder of the meeting was spent discussing the possibility of establishing an Office of Education within the APA central office. It was noted that two major aspects of education have been represented in the staff through the Office of Continuing Education and the *Physician Education Project.* It was also noted that many other aspects of APA activities are of an educational nature (e.g., the annual meeting, the Institutes on Hospital & Community Psychiatry, the Colloquium, publications, etc.).

A new Office of Education could concern itself with a full range of interests in education, possibly beginning with precollege, and certainly extending through medical school, residency training, and the professional lifetime of APA members. It was felt that the primary function of such an office would be to initiate and coordinate the numerous education functions and activities now going on as well as others that might be planned. Included in such coordinating responsibility would be the establishment and maintenance of liaison with other educational and certifying bodies such as the ABPN and the AAMC.

While it seemed clear that the Council should have the responsibility for policy formulation vis-a-vis educational matters and would be advisor to other parts of APA, the staff office would carry out policy. In addition, there could be an outreach from the staff office involving the district branches and the various areas in specific programs for continuing education, particularly the education of our own members. Although APA has taken on a responsibility in the area of self-assessment, the Association would only act in an advisory capacity in recertification.

The Reference Committee responded to the Council's proposals in June 1974 by approving an ad hoc subcommittee of the Commission on History for the purpose of coordinating APA plans for the bicentennial celebration. The Reference Committee also supported the Council's position on the reestablishment of the internship and approved in principle the concept of an Office of Education within APA.

The Council met again at APA headquarters, Washington, D.C., October 17 to 19, 1974. The Council chairman's response to the Reference Committee survey questionnaire was reviewed. This led to discussion on the goals and objectives of the components, and it was suggested that these be more clearly spelled out within the components and that the committee chairpersons, as they report, state the various issues of major concern to their groups. It was again pointed out that there was so much emergency material that the major issues of education were being bypassed. An additional meeting of the Council and of its components in the spring to plan policy, etc., was tentatively planned for March.

The Council endorsed the establishment of the Office of Education of APA. The Council also developed guidelines for the Medical Director in finding a director of the Office of Education.

Dr. Jeanne Spurlock requested that the Council make recommendations concerning membership on the *Selection Advisory Committee, Minority Fellowship Program*; this was done.

Marc Hollender, M.D. (liaison with the ABPN), stressed that APA has a major input into the ABPN. He also noted that there recently has been a much more open attitude on the part of the ABPN. Interest has been expressed in certification in special competency such as already exists in the field of neurology, i.e., "Special Competence in Child Neurology."

A committee is working on the entire problem of recertification. The recertification would probably relate only to the specific area in which an individual is practicing. The Council discussed with Dr. Hollender the refusal of the ABPN to take on the problem of recertification in administrative psychiatry. The ABPN felt that administrative psychiatry was not an area that would merit special competency certification. There was a feeling that too many other areas (geriatrics, forensic psychiatry, etc.) would seek certifying procedures.

The Council noted that although there are a number of APA members on the ABPN, the feedback is poor. It was suggested that communication before any contemplated action is taken would be extremely worthwhile. It was also suggested that when the Office of Education is established, it could also be a vehicle for relating to the ABPN.

Harold Kaplan, M.D., chairman of the *Committee on Medical Education*, commented on the report from the Task Force on Goals and Priorities of the NBME. In view of this task force's concern about lack of communication between the NBME and APA on educational matters, the Council agreed that it should negotiate with the NBME concerning interaction on psychiatric input to the NBME exams.

The Council approved the request of the Committee on Medical Education that the APA negotiate with the NBME so that one of its members (Committee on Medical Education) or other suitable representative could become a participating member of the NBME examining panels (parts one and two).

A second recommendation of this committee was that a task force be established to determine the role of a behavioral science curriculum during the first two years of medical school training. This was tabled pending the receipt of further information from the commissions associated with the impending Conference on Psychiatric Education.

The Council approved the committee's request that APA explore the possibility of liaison with the AAMC with a view toward determining and guiding behavioral input in the Medical College Aptitude Test (MCAT).

The committee's Task Force To Plan a Conference on Family Life Education has been unable to obtain financial backing. It recommended cosponsorship by a number of different organizations, but little progress has been made. The committee recommended that the project be rejected since it is different than that previously approved. The Council recommended that the Task Force To Plan a Conference on Family Life Education be terminated.

The *Task Force on School Consultation* has completed a manuscript and will deliver it to the committee with the reports of two referees. It will then be forwarded to Council for its action.

The *Committee on Graduate Education*, Henry Coppolillo, M.D., chairman, requested that it have liaison with APA components attempting to define the professional role and profile of a psychiatrist and expressed a desire to work to develop core curricula as well as techniques for the training and education of students to achieve the goal of producing competent psychiatrists; the Council endorsed both of these requests.

There was considerable discussion about the Internship Matching Plan. The Council endorsed this committee's request that APA through the Medical Director's office contact other psychiatric education organizations to get their reactions to the matching plan and forward this to the Committee on Graduate Education for its study and reaction.

The Council also endorsed the idea that the Office of Education should carry out a coordinating function in this area.

An interim report from the *Task Force on Research Training*, Frederic G. Worden, M.D., chairman, was received and briefly reviewed. This task force will produce a paper documenting the need for and techniques of research training.

A report from the *Subcommittee on Foreign Medical Graduates*, Tsung-yi Lin, M.D., chairman, was approved, and it was recommended that it go back to the Assembly prior to submission to the Reference Committee.

The desirability of creating a task force dealing with the interface in the training of psychiatry and other mental health professionals was discussed; it will be continued at a later meeting.

The report from the *Committee on Continuing Education*, Robert A. Senescu, M.D., chairman was received with thanks. The group in liaison with the American College of Physicians noted that APA members from this group are paid by the college to attend their meetings and requested that APA explore the possibility of paying the way of members of the college to attend APA meetings. The Council endorsed this request.

The liaison group has pointed out that, while part of their function is education, their liaison functions go far beyond merely the educational; they believe that they have been inappropriately placed in this Council. The Council recommended that the group in liaison with the American College of Physicians be transferred to the Council on Professions and Associations. The Council approved the committee's recommendation that the colloquium be postponed until the summer and also endorsed the committee's wish that it and its components meet in the spring (at the same time as the Council) so that the entire area can be thoroughly reviewed. The relationship of this committee and its components to the Office of Education would be thoroughly aired.

The report from the *Commission on Certification in Administrative Psychiatry*, Dean K. Brooks, M.D., chairman, was received with thanks. It should be noted that this commission did not meet but submitted a written report. The role of the APA in certification in administrative psychiatry and other areas was again reviewed.

The Council after a thorough discussion recommended that certification in administrative psychiatry by APA come to an end in 1980 since it is regarded that this is an inappropriate function for APA.

The report from the *Commission on History*, David F.

Musto, M.D., chairman, was received with thanks. The Council supported the recommendation of the commission that a task force on the syllabus, chaired by Dr. Daniel Blain, be established and that a $2,000 budget be requested. It also recommended that because of the commission's role in the bicentennial this commission be continued until 1977.

The Reference Committee responded to the Council's proposals in November 1974 by approving the Council's recommendation that APA explore with the NBME the possibility of a liaison with more membership on examination panels. The Reference Committee also approved the recommendation of the Council for a liaison with more membership on examination panels and the recommendation of the Council for a liaison with AAMC, with a view toward better psychiatric and behavioral science input by APA members into the MCAT.

The Reference Committee approved the Council's recommendation that the Task Force on Family Life and Education be terminated, agreed to recommend to the Board of Trustees that certification in administrative psychiatry ultimately be terminated by APA, and approved an extension of the Commission on History until 1977 so that its activities in the bicentennial can go forward.

At its meeting in December 1974, the Board of Trustees endorsed the actions of the Reference Committee.

The Council on Mental Health Services

JAMES C. JOHNSON, M.D., CHAIRMAN

THE COUNCIL ON MENTAL HEALTH SERVICES held only one meeting in 1974 (in October) and succeeded, in conjunction with its numerous components, in overspending its budget by $1,541.31. This amount will probably be increased by necessary additional meetings of the Task Force on Collaboration of Psychiatrist and Consumer, the Task Force To Study the Status of Nursing Homes, and the Task Force on Problem-Oriented Records. In view of these fiscal facts, the Council does not contemplate another meeting until October 1975.

The survey comparing human service systems with independent departments of mental health in various states has been completed. The Council reviewed all of the survey material, and brief summaries of these responses indicated that the majority of district branches preferred a psychiatrist to head the mental health administration, that they preferred a separate department of mental health, and that, whatever the structure, they felt the program administrator should have direct access to the governor and the legislature of each state. The Council recommended that district branches be reminded that the existing policy statement (September 4, 1970) as well as the results of the survey will be used until the Council revises its existing policy statement. In addition, it recommended that the policy statement be revised and updated and a documentary preamble be added that will justify its conclusion; this draft will be considered at the next meeting.

The Council had been asked to consider establishing a task force to study the entire question of rehabilitation. When this suggestion was submitted to the Reference Committee in November, the question was referred to the Council on Professions and Associations for consideration by the newly forming Task Force on APA Liaison Activities for appropriate liaison with rehabilitation agencies.

Because of a lack of time and manpower in the face of proliferating demands for topics to be studied, and in order to serve the needs of children and adolescents as they relate to the responsibilities of APA, the *Commission on Childhood and Adolescence*, Violá Bernard, M.D., chairwoman, recommended 1) the formation of a Council on Childhood and Adolescence, with representatives from general psychiatry, child and adolescent psychiatry, and administrative psychiatry; 2) that the Assembly appoint an observer to the Council on Childhood and Adolescence to facilitate communication between the Council and the Assembly; 3) the formation of a number of task forces to develop policy and action papers for APA on the issues of—in order of priority—state government patterns for delivery of mental health services to children and adolescents, establishment of guidelines for the duration of treatment and treatment modalities of residential and inpatient services for children and adolescents, special problems of confidentiality in the treatment of children and adolescents, and mental health implications of alternatives to traditional family styles and structures.

It was also recommended that APA take the position that the amount of staff time that each community mental health center allocates to services for children and adolescents be proportionate to their numbers in the catchment area served by that center.

The recommendation for the formation of a Council on Childhood and Adolescence was deferred by the Reference Committee, with the recommendation that the commission organize its members into subgroupings to be charged with study of the proposed items. It further recommended that the Commission on Childhood and Adolescence explore means of informational liaison with the National Council of Organizations for Children and Youth and strongly urged the Commission to prepare a position paper to be presented by the Reference Committee at the upcoming Key Conference.

Under the threat of curtailment of mental health benefits by CHAMPUS, the *Committee on Federal Government Health Services*, Stewart Baker, M.D., chairman, established liaison with the Commission on Standards of Practice and Third-Party Payment and submitted recommendations for peer review of CHAMPUS and other federal programs of reimbursement at the national and district branch levels. This committee reported a continuing decrease in the number of military psychiatrists, a

reduced availability of services, particularly for dependents and retired personnel, and increasing provision of mental health services by other mental health professionals such as psychologists and social workers. There is also evidence that there are problems in gaining approval for the implementation of a service-wide child advocacy program with the Department of Defense. With reduction of federal support, many community mental health centers are suffering increasing financial difficulties, particularly when they are not supported by state funding. The committee recommended that APA refer this problem to the attention of NIMH and requested early focus on the needs for improved mechanisms of transition from federal grant support to other modes of funding.

The *Committee on Financing Mental Health Care*, William H. Goldman, M.D., chairman, submitted a progress report enumerating recommendations of principles on insurance coverage for mental illness. A benefit package has been developed and studied by the committee. After its December meeting it was ready to draft a final document, from which a revised statement on mental health coverage under national health insurance can be developed by APA. A final report should be received by April 1975.

The *Task Force on Peer Review*, Frank Sullivan, M.D., chairman, has completed its work and submitted its final report, recommending that the entire field of peer review be an ongoing consideration of APA, that the task force be dissolved and be replaced by a Committee on Peer Review composed of a small number of individuals, and that a full-time psychiatrist be appointed as a director of the Office of Peer Review in the APA central office. The Board of Trustees authorized the establishment of such a committee, which will be appointed in May 1975.

In addition to the Committee on Peer Review, a task force to develop screening criteria has been appointed to accomplish the work set forth in the AMA subcontract with APA to update our PSRO material. This task force held its first meeting January 17 to 18 and will submit a report at the annual meeting.

The progress report of the *Task Force on Suicide Prevention*, Matthew Ross, M.D., chairman, described an ambitious program for continuing their activities of attaining psychological autopsies on a selected sample of 100 incidents. Because of fiscal considerations and the fact that other groups are engaged in such studies, the Reference Committee and the Council recommended that a time limit (October 1975) be established to complete the original charge and make a final report, which could contain recommendations for future studies as indicated.

The *Task Force To Study the Status of Nursing Homes and Other Extended Care Facilities*, Seymour J. Viener, M.D., chairman, has held two meetings and will complete its work with supportive documentation by April 1975. They have used existing organizational definitions of nursing homes and extended care facilities, recommendating standards of practice, staffing, and environmental protection derived from a variety of sources and applied to these specific facilities.

The *Task Force on Problem-Oriented Records*, Richard L. Grant, M.D., chairman, has held three meetings and will complete the first phase of its work by April 1, 1975. The task force has recommended that APA consider a permanent component on psychiatric records in the central office in order to develop and maintain uniform standards of record keeping, utilization of records, and updating such standards as necessary.

The *Task Force To Develop a Mini-CPT*, Leigh M. Roberts, M.D., chairman, has completed its work and submitted a draft for an expanded, annotated "Procedure Terminology for Psychiatrists." The Reference Committee has approved its recommendation that 25,000 copies be printed and distributed to the APA membership.

The *Task Force on Collaboration of the Psychiatrist and Consumer in Psychiatric Programs*, June J. Christmas, M.D., chairwoman, has held three meetings, during the course of which several preliminary drafts of a position statement have been reviewed. It has recommended that the task force be renamed the Task Force on Collaboration of Psychiatry and Citizens in order to broaden the representation of input deemed necessary for APA. A final position statement will be available between now and the annual meeting.

The *Task Force on APA Standards for Psychiatric Facilities*, William S. Allerton, M.D., chairman, completed its work and was disbanded following publication of the recommended revisions.

The *Task Force on Private Psychiatric Hospitals*, John H. Houck, M.D., chairman, completed its work and will submit a final report by May.

The *Task Force on Psychiatric Rehabilitation in Correctional Systems*, Francis A. Tyce, M.D., chairman, has had numerous difficulties in membership, meeting times, and work potential. It is hoped that it will be able to complete a report by October 1975.

The Council continues to review its own functioning as well as that of its various components. One of the problems that confronts the Council is the repeated tendency of its components to attempt to redefine, broaden, or change their original charges, thus developing additional areas of concern, which prolongs the life of a task force or may require conversion to a committee. There are also increased recommendations for permanent staff to be responsible for a variety of specific topics in the central office. In spite of the Council's admonitions and attempts at containment, this practice seems to be burgeoning.

The Council on Research and Development

JOHN J. SCHWAB, M.D., CHAIRMAN

DURING THE PAST year the Council conducted two working sessions, one in April and the other during the fall committee meetings. Lester Grinspoon, M.D., and Walter W. Shervington, M.D., replaced Russell R. Monroe, M.D., who had completed his five-year term, and Seymour S. Kety, M.D., who resigned from the Council. James H. Carter, M.D., replaced Walter W. Shervington, M.D., as observer/consultant. E. Ivan Bruce, Jr., M.D., continued serving as the assembly liaison. "Report No. 8, Clinical Aspects of the Violent Individual," edited by John R. Lion, M.D., and Donald P. Kenefick, M.D., was published in October 1974.

A significant portion of the Council's energy and time has been devoted to the subject of psychiatrists' role conflicts. In 1973 the Council reviewed a number of research proposals designed to study conflicts between psychiatrists' institutional and therapeutic roles and the extent to which psychiatrists serve as agents of social control. The Council recommended to the Reference Committee that the Board of Trustees endorse and seek funding for two complementary studies. One is a focused "Survey of New Jersey Psychiatrists' Role Perceptions," which would be conducted by Claudewell S. Thomas, M.D., and Clyde Sullivan, Ph.D., from the New Jersey College of Medicine and Dentistry. The second is a more comprehensive, socioanthropologic evaluation of psychiatrists' role conflicts and the profession's involvement in governmental, legal, ethical, and therapeutic issues as a mechanism for social control, which would be undertaken by the Institute of Society, Ethics, and the Life Sciences, Hastings Center, New York. Some limited funding from the Association has been obtained for the New Jersey study, which will entail a 100-percent sampling of psychiatrists in that state in order to obtain greater understanding of both the nature and the extent of their role conflicts. No funding, however, has been obtained for the more major study; currently, the principal investigators are revising the research design before submitting the proposal for funding.

Four new task forces have been established.

Samuel B. Guze, M.D., accepted the chairmanship of the *Task Force on Ethics in Research.* Already, the task force is studying a series of research protocols in which ethical considerations are problematic if not controversial. The task force's mandate is to evaluate existing regulations and develop a model that will serve as a background for their studies of research protocols which present ethical problems. From their critique of the regulations and their analysis of research protocols, the task force will develop a code of ethics for psychiatric research. The Council's liaison member to the task force is Louis Jolyon West, M.D.

A *Task Force on Electroconvulsive Therapy* has been approved for a two-year period. The task force's charge is to conduct a "state of the art" review of the current literature and ongoing research on ECT in order to develop a position paper for the Association and supply up-to-date guidelines regarding the indications for and the results of ECT. The liaison member is Lester Grinspoon, M.D.

The new *Task Force To Study the Problems of Aging Psychiatrists* will undertake to determine the number, locations, and professional activities of psychiatrists over 65 years of age. Then, the task force will offer suggestions and develop guidelines for further research on aging psychiatrists' roles, special capabilities, and the difficulties they encounter. Possibly a special office in APA could serve a useful function by providing information about part-time positions and other professional activities suitable for aging psychiatrists facing retirement or those already retired who wish to continue some type of professional activity. Appointments to the task force will be made at the April 1975 Council meeting.

The Council will develop a charge for the new *Task Force on Relationships Between Psychiatry and Psi-Phenomena* and will begin working on appointments to the task force at the April 1975 meeting.

The *Task Force on Innovative Approaches to DSM-III* has been merged with the *Task Force on Nomenclature and Statistics*, Robert Spitzer, M.D., chairman. The task force, which is working vigorously on *DSM-III*, consists of one central committee and four subcommittees. The central committee is charged with the overall responsibilities for *DSM-III*; each of the subcommittees will focus its efforts on one of the four following major topics: psychosis, personality, childhood, sexual disorders. The nine subjects that will serve as the table of contents for *DSM-III* are 1) the definition of mental disorder, 2) a defense of the medical model, 3) operational criteria for the diagnostic categories, 4) a nomenclature for psychosocial problems, 5) the validity of psychiatric disorders, 6) a provision for undiagnosed psychiatric disorders, 7) a bibliography of standard references, 8) a glossary, and 9) an index. A final draft is scheduled for 1977; *DSM-III* will be published in 1978.

The *Commission on Drug Abuse*, Daniel X. Freedman, M.D., chairman, has been asked to perform many functions and, of necessity, has had to respond to emergency requests from the APA central office for statements on and immediate reviews of critical issues. Thus, the commission has had to function as an advisory body as well as a group interested in research in this field. Moreover, the commission's roles and activities cut across many lines and involve numerous other councils. In view of these considerations, the Board of Trustees decided to terminate the commission in May 1975. The Council will appoint task forces to study specific research problems related to drug abuse and alcoholism. The Reference Committee and the Board of Trustees will search for a more definitive structure for the commission's other roles and functions.

The *Task Force on Methadone Therapy and Narcotic Antagonists*, Roger E. Meyer, M.D., chairman, has submitted a final report that is being edited for publication as one of the Association's task force reports.

The *Task Force on Lithium Therapy*, Irvin M. Cohen, M.D., chairman, has completed its work and is editing its final report. During the next few months the task force will be completing both an in-depth report on the current status of lithium therapy and a summary that will be submitted for publication as an article in *The American Journal of Psychiatry.*

The *Task Force on the Effects of Television on Mental Health*, James H. Ryan, M.D., chairman, submitted a progress report at the October meeting. The task force thinks that watching television does not have adverse effects provided the viewer is a mentally healthy individual. The task force has

found some evidence for possible "television addiction," particularly in adults and children whose mental health states are borderline or fragile. Questions are being raised about the extent to which television enriches life for deprived persons and whether television is meeting its responsibilities to improve the quality of life in America. This task force is now preparing its final report, which should be ready for review at the Council's April meeting.

The *Task Force on Biofeedback*, Martin T. Orne, M.D., chairman, is proceeding with its work. It will be focusing its efforts on evaluating biofeedback in four major areas: cardiovascular, muscular, temperature control, and EEG. Bernard C. Glueck, M.D., is the Council's liaison to the task force.

The *Task Force on Meditation*, James Morgan, M.D., chairman, has met once and is enlarging its group. The task force is preparing a questionnaire to gather psychiatrists' opinions about meditation as therapy. Also, the task force is searching for reports of adverse reactions to transcendental meditation. Bernard C. Glueck, M.D., is the Council liaison.

The *Task Force Relative to Research Evaluation of Racism*, Claudewell S. Thomas, M.D., chairman, is working on the context and the content of psychiatric research, the role of the community in research, and the differences between evaluation and research. This task force is studying accountability, role models, and who is receiving research support. For each of these items the position and the participation of minority groups will be examined.

The *Task Force on Evaluation Research in Community Mental Health Centers*, Gerald L. Klerman, M.D., chairman, recommended that APA accept an invitation by NIMH to submit a grant proposal on forming an office on evaluation research.

The *Task Force on Psychiatric Aspects of Aerospace Program* will remain inactive until the Council ascertains whether sufficient information is available to warrant the expenditure of funds and energy to study this topic at this time.

The Council expressed its appreciation to the Falk Fellows, Nelson Handler, M.D., Robert L. Heins, M.D., Scott Saunders, M.D., and Conrado Weller, M.D., for their vigorous participation, enthusiasm, new opinions, and willingness to grapple with the Council's activities and problems. The Council also thanked James H. Carter, M.D., observer/consultant, and E. Ivan Bruce, Jr., M.D., assembly liaison for their invaluable contributions to the Council's work.

The Council on National Affairs

JAMES M. BELL, M.D., CHAIRMAN

THE COUNCIL CONTINUED under the chairmanship of James M. Bell, M.D., who had been reappointed. The Council welcomed the addition of three new members: Hiawatha Harris, M.D., Jean S. Bolen, M.D., and Frank M. Ochberg, M.D. Our observer/consultant, Esther P. Roberts, M.D., and staff liaison, Jeanne Spurlock, M.D., were also assigned to the Council. Julian Barish, M.D., returned as vice-chairman, W. Payton Kolb, M.D., returned as assembly liaison, and Bertram Brown, M.D., returned as consultant. In spite of the many changes, the year was a most productive one. In addition to the formal fall meeting we held informal gatherings at the annual meeting and two telephone conferences.

At the October 1974 meeting each member was given personal responsibility for a component under the auspices of the Council on National Affairs. This required that time be spent at actual meetings of the component as a representative of the Council. In addition each component chairman was invited to meet with the Council to review his current activities. Much of the Council time was spent, in addition to reviewing the status of components, reviewing the Council work itself. The recommendation for new components, termination of others, and the position statement on foreign medical graduates, written by Dr. Lin, were discussed (Dr. Lin was in attendance). At this point the Council is very active and all members and components are very much involved.

The *Task Force on Delivery of Psychiatric Services in Poverty Areas*, Quentin A. F. Rae-Grant, M.D., and Arland B. Lightfoot, M.D., cochairmen, formed in 1971, had a two-phase objective: 1) to review role functions, problems, and successes of CMHCs in poverty regions and to identify key subject matter areas that would lend themselves to policy recommendations; and 2) to analyze selected subject areas and make policy recommendations.

Last year the task force recommended the formation of a commission to carry out specific recommendations developed in the course of its work. The two primary goals of the commission would be 1) to ensure a continuing presence within APA that will pay attention to the many and diverse problems in the area of providing psychiatric services to poverty groups and 2) to coordinate the many discrete activities that have not proved productive for the Association and have resulted in disparate actions. The Council identified another goal, the prioritization stemming from the work of the task force.

The *Committee of Black Psychiatrists*, James P. Comer, M.D., chairman, continued activities directed toward the goals of consciousness raising (of membership and other mental health service givers and educators) regarding minority group mental health issues. The committee supported the development of a Deputy Medical Directorship, within APA, that includes a minority affairs component.

The committee was also active in its support of the development of a research and mental health program center (the Solomon Fuller Institute) independent of established institutions and in continued support of the work of the NIMH Center for Minority Mental Health Programs. A major activity at the committee's last formal meeting (October 1974) related to the development of a program to coordinate the work of The Solomon Fuller Institute, the NIMH Center for Minority Mental Health Programs, and the APA Office of Minority Affairs. At the fall meeting, the committee finalized plans for the presentation to be made at the 1975 annual meeting, including the examination of strengths of the black family and the interface between the black family and the public school. The outgoing chairman, Dr. Comer, reported that the committee is now prepared to give more attention to its organizational structure, and he has proposed the development of a structure that would permit the committee to speak regularly and perhaps independently of APA when urgent issues relative to the mental health of blacks arise. A third phase of the committee's mission is to be that of addressing the functioning of black adolescents and black treatment issues.

Bruce L. Ballard, M.D., was recommended to represent the Committee of Black Psychiatrists on the Selection/Advisory Committee, Minority Fellowship Program.

The *Task Force on the Mental Health of Spanish-Speaking People in the United States*, chaired by Angel Gregorio Gomez, M.D., has worked actively toward accomplishing the following goals: 1) identification of a number of problem areas confronting the Spanish-speaking populations and the psychiatrists serving these groups, 2) development of a directory of Spanish-speaking psychiatrists in the United States, 3) study of procedures that would support the development of adequate mental health services for the Spanish-speaking community, and 4) study of ways to develop a sense of advocacy in APA members, with special emphasis in those regions with large Spanish-speaking populations.

The task force has also been addressing itself to issues of particular concern to Spanish-speaking psychiatrists and has served as an advocate body within APA for the Spanish-speaking community. Efforts have been directed toward fostering cohesion among Spanish-speaking psychiatrists. Exchanges of information were achieved at the 1974 annual meeting through informal meetings in a hospitality suite and in formal panel discussions. A similar plan will be implemented during the 1975 annual meeting. An additional input at the 1975 meeting will be a special presentation, the Simon Bolivar Lecture. Dr. Pedro Ruiz was recommended to represent the Task Force on the Mental Health of Spanish-Speaking People in the United States on the Selection/Advisory Committee, Minority Fellowship Program.

Anticipating completion of the identified goals, Frank Ochberg, M.D., chairman of the *Task Force on Third-Party Intervention in Community Crisis*, recommended that this component be phased out before the 1975 annual meeting. A final task was to search for private funding for the purpose of printing and distributing the proceedings of the national conference conducted by the task force in 1973 and to circulate to APA members and to analyze a questionnaire pertaining to intervention in community crises. Dr. Burr Eichelmann has volunteered to be responsible for the analysis and for reporting the findings to the Council.

James H. Shore, M.D., assumed the chairmanship of the *Task Force on Indian Affairs* during the sabbatical of Dr. Morton Beiser. One of the major activities of the task force has been to identify Indian members and invite their participation in the activities of the task force. A national workshop focusing on the

mental health of Indian youth will be convened in Portland, Ore., in February. A generous contribution of $10,000 has been given by the Ittleson Family Foundation to support the project. Plans are in the making for establishing a dialogue with urban Indian groups (a beginning will take place, with the Urban Indian Center in Los Angeles, during the 1975 annual meeting) and the Canadian Psychiatric Association's Indian task force. Other activities of this component include drafting the report of the evaluation contract with the Indian Health Service, submission of a proposal to NIMH for the preparation of an annotated bibliography on Indian mental health, and proposals submitted to NIMH for the formation of a national research and development center for American Indians in mental health. Dr. Johanna Clevenger was recommended to represent the Task Force on Indian Affairs on the Selection/Advisory Committee, Minority Fellowship Program.

Following the expiration of the comprehensive health planning legislation on June 30, 1974, the *Task Force on Comprehensive Health Planning*, chaired by Robert Williams, M.D., followed the development of new legislation and actively engaged in efforts to modify the bill to include mental health in comprehensive health planning and mental health professionals on the planning boards. Informal liaison was established by the task force with the National Association of Mental Health Program Directors in an endeavor to obtain support from the Committee on Interstate and Foreign Commerce of its efforts to modify the bill along these lines. Contact was made with the author of the bill, National Health Policy, Planning, and Resources Development Act of 1974 (HR-16204), and a request was made for the inclusion of mental health as well as the appointment of mental health professionals to the various health planning bodies. The task force plans to develop a report to be used as a handbook for APA members involved in comprehensive mental health. (Note: This bill became Public Law 93-641 on January 4, 1975.)

Jay Shurley, M.D., accepted the chairmanship of the *Task Force on Ecopsychiatric Data Base*. The Council on National Affairs approved the following charge as described by Dr. Shurley: to attempt a fresh conceptualization, organization, and publication of a sufficiently substantial and comprehensive data base, from the scientific and clinical literatures and from research in progress, to form a substrate and framework upon which psychiatric knowledge and practice can advance as a consequence of the further enhancement of awareness of the manifold relationships existing between ecology and mental health.

The *Ad Hoc Committee on Legislative Network*, Hayden H. Donahue, M.D., chairman, in conjunction with the staff of the Office of Government Relations of the central APA office, outlined the following principles for an effective legislative arm for the organization: 1) the Assembly of District Branches and the Board of Trustees are to formulate and set APA policies and priorities that form the basis for determining legislative activities in any given year; 2) the carrying out of APA's action with regard to any specific legislative or executive branch issues is to be made by the Medical Director, under the direction of the President and the Board of Trustees; 3) the Legislative Commission, developed from the Ad Hoc Committee on Legislative Network, is to have the responsibility to advise the Medical Director with regard to what action APA should take and to advise the Assembly and the Board of Trustees regarding APA priorities; and 4) in order to allow for rapid action when needed, the Medical Director is to initiate APA action, in consultation with the President, the Speaker of the Assembly, and the chairman of the Legislative Committee.

To carry out these principles, the ad hoc committee recommended that a number of functional relationships be established within the current organization of APA. The Council on National Affairs referred the entire report of the ad hoc committee to the Board of Trustees for their consideration, along with a recommendation that the Legislative Commission should not be developed into a second assembly.

Two new components are scheduled to become active under the umbrella of the Council on National Affairs: the *Committee on Women in Psychiatry*, an outgrowth of the *Task Force on Women in Psychiatry*, was transferred from the Council on Emerging Issues; and the *Ad Hoc Committee of Asian-American Psychiatrists* will convene a caucus at the 1975 annual meeting. The Council approved the charge recommended by member Jean Shinoda Bolen, M.D., i.e., the committee will determine whether Asian-American psychiatrists have a common identity as a group and have specific concerns as Asian-American psychiatrists. It will also have the task of exploring areas of psychiatric need specific to Asian-American people. The Council, recognizing that there are differences among Asian-Americans, recommended the formation of an ad hoc committee rather than a task force at this time. A core membership has been appointed to begin the work of the component before the annual meeting. Dr. Sanford Tom will represent the Ad Hoc Committee on Asian-American Psychiatrists on the Selection/Advisory Committee, Minority Fellowship Program.

The Council on International Affairs

NORMAN ROSENZWEIG, M.D., CHAIRMAN

THE COUNCIL ON INTERNATIONAL AFFAIRS continued in its primary objective of establishing and maintaining positive relationships with psychiatrists in other countries through personal contacts, the development of international meetings, liaison and international activities, and its hosting of activities at APA annual meetings.

The provision of services and help for foreign visitors at the annual meeting in Detroit was eminently successful, and similar arrangements are being planned for foreign guests at the next annual meeting in Anaheim, Calif. A special booth for the registration of foreign guests will be set up, and arrangements for individual hosting of foreign guests by members of the Southern California District Branch are in process.

The *Inter-American Council of Psychiatric Asssociations* sponsored the Inter-American Conference on Mental Health of Children and Youth in Mexico City, January 30 to February 1, 1975. Howard Rome, M.D., obtained financial assistance for the conference from the Grant Foundation. The Council's *Task Force on Transcultural Aspects of Mental Health of Children*, chaired by Jorge M. Velasco-Alzaga, M.D., was actively involved in the conference and contributed significantly to its success.

Plans are proceeding apace for the World Psychiatric Association meeting in Hawaii in 1977. The President of APA, John P. Spiegel, M.D., appointed Shervert Frazier, M.D., chairman of the Organizing Committee, Gerald Sarwer-Foner, M.D., chairman of the Program Committee, and George Schnack, M.D., chairman of Local Arrangements.

The *Task Force To Plan the Joint Meeting in Australia 1975*, chaired by Alfred Auerbach, M.D., is finalizing arrangements for the meeting in Australia, which will follow the APA annual meeting in Anaheim. The First Pacific Congress of Psychiatry will be held in Melbourne, May 11–16, 1975. (Specific information about the schedule and arrangements may be obtained from the APA Convention Office).

The *Task Force on Transcultural Aspects of Ethnocentricity Among Psychiatrists* met in Washington in October 1974 and continued its work on the questionnaire that will be used to study ethnocentrism among APA members. Dr. Ramon Parres, the chairman, is seeking a grant to augment funding for the administration and evaluation of this study, expected to take about two years.

The *Task Force To Plan a Joint Meeting with Scandinavian Psychiatric Societies 1976*, chaired by Robert S. Garber, M.D., has met with complications in trying to arrange a joint meeting in 1976. The Swedish Psychiatric Society is planning to send a delegation to visit the United States and to attend the APA annual meeting in Anaheim. This task force is working with the Program Committee to arrange panels and participation as discussants for the Swedish psychiatrists and with the *Task Force on Arrangements* in Anaheim to plan special activities.

A redefinition of objectives has been outlined by the *Task Force on Liaison with International and Foreign Psychiatric Organizations*. In order to promote contact and liaison with other psychiatric organizations, a pilot program will be set up assigning individuals to maintain a liaison relationship with their counterparts in 1 of 10 foreign countries selected by the task force. This initial project will take about two years, and if it is successful it may prove a useful guide for establishing and maintaining contacts with foreign psychiatric associations.

Participation in a series of presentations and discussions on the Arab-Israeli conflict has been undertaken by the *Task Force on Psychiatric and Foreign Affairs: Psychological Aspects of Near Eastern Studies*. Members of the task force have had meetings with Princeton University faculty members concerning Near Eastern studies. They have also presented a program at New York Medical College concerning Middle Eastern problems and participated in a briefing session at the U.S. State Department. William D. Davidson, M.D., chairman of the task force, reported to the Council at the fall committee meetings in October 1974 on the meeting planned at the University of London in December 1974 with certain Arab leaders to explore possible contributions to resolving the current Arab-Israeli dispute.

The fourth edition of *A Psychiatric Glossary* is being translated into Spanish by a task force headed by Jorge M. Velasco-Alzaga, M.D. This is the first of what we hope will be a series of translations of official APA publications.

The Council on Professions and Associations

LEWIS L. ROBBINS, M.D., CHAIRMAN

WILLIAM L. SORUM, M.D., has become a member of the Council, replacing Louis Linn, M.D., whose term expired. The Council has been asked to review all the liaison activities of APA and is accordingly establishing a task force for this purpose. Liaison activities are currently carried out at several levels: presidential appointments to other organizations, staff liaison functions, and formal and informal liaison activities by committees and task forces. The new task force will obtain information about what is going on in all these areas, assess the efficacy and value of these various liaison activities, and identify areas where liaison is needed but absent or not needed but present. From these studies and from the deliberations of the Key Conference in March, the task force will make recommendations regarding future liaison activities and their place within APA.

Inasmuch as the Council's concern with APA's liaison activities has been extended, the *Committee on Liaison with the American College of Physicians*, Charles P. Neumann, M.D., chairman, has been transferred back to the Council on Professions and Associations. Meeting together with representatives from the American College of Physicians, the objectives and functions of this committee were reviewed. These include 1) maintaining a positive impact on shared areas of patient care, thereby enhancing the interrelationship between internal medicine and psychiatry, 2) supporting high standards of practice in both professions insofar as their functions mesh in the understanding and treatment of the whole patient, and 3) providing educational programs for both the internist and the psychiatrist on a continuing basis to achieve these high standards of relatedness. Methods for achieving these objectives were also developed. Plans for continued participation in each organization's annual meeting were developed.

The *Committee on Liaison with the American Hospital Association*, Francis deMarneffe, M.D., chairman, met with the American Hospital Association. The primary problems discussed were financing of hospital service, the need for removing the distinction between physical and psychiatric acute care patients, the qualify of life in institutions such as general and psychiatric hospitals and nursing homes, and peer review and standards for accreditation of general hospital psychiatric units.

The *Committee on Psychiatry and the Law*, Stanley L. Portnow, M.D., chairman, proposed that APA establish a Committee on Certification in Forensic Psychiatry which would develop training standards and training programs in this area. This was rejected in view of APA's policy decision to discontinue its activity in certifying further subspecialities.

At its October meeting this committee established an ongoing relationship with the Mental Health Law Project, which consists of a group of lawyers interested in litigating civil rights of the mentally ill. Like the existing relationship with the American Bar Association, it is anticipated that this will facilitate the work of all three groups. Among the topics discussed were federal rules on privilege and confidentiality that are before a Senate committee, model legislation regarding committment, and Senate bills regarding the insanity defense. The committee is continuing to develop a position statement concerning informed consent of prisoners, with particular reference to psychosurgery.

The committee considered the guidelines for prearraignment psychiatric examination that have been proposed by the San Diego Psychiatric Society. In view of the possibility of self-incrimination, suspects are more in need of legal counsel before submitting to psychiatric examination and evaluation; even when such examination is ordered by legal authority, guidelines relative to informed consent are applicable. These issues have been passed on to the Assembly and the district branches for their information and comment.

The question of establishing a Council on Psychiatry and Law in view of the volume and breadth of the work of this committee has been tabled pending the deliberations regarding reorganization of APA that will take place at the forthcoming Key Conference.

The *Committee on Psychiatric Nursing*, William E. Stone, M.D., chairman, again in collaboration with the American Nurses Association, held a session at the 1974 Institute on Hospital & Community Psychiatry. In view of the attendance and response, publication of the proceedings and continued participation in these institutes are planned. Also in collaboration with the American Nurses Association, this committee is preparing a joint statement on clinical nurse specialists.

The committee's recommendation for the establishment of a task force to look at issues related to emerging paraprofessional groups working (often independently) in mental health settings is being studied by the Council.

The final report of the *Task Force on Confidentiality as It Relates to Third Parties*, Maurice Grossman, M.D., chairman, has been approved and, pending final publication, copies have been distributed to the delegates to the Assembly of District Branches and other interested organizations and individuals. The Assembly has established a task force to implement the pilot program to test the proposed coding system for health insurance claims in California and Connecticut.

The task force is being continued until APA establishes a permanent structure to deal with problems of confidentiality that will continue to arise. Although at the recent conference on confidentiality held in Key Biscayne it was decided to establish a national organization for this purpose, it has been agreed that APA also needs a commission or committee to concern itself with the special problems concerning psychiatry.

The task force's report on the role of confidentiality in voluntary military drug abuse treatment programs has been approved by the Board of Trustees.

The task force is planning a monograph on problems of confidentiality and has also consulted with other APA task forces and committees about their deliberations in which issues regarding confidentiality have arisen.

The *Task Force on Right to Treatment* has been reestablished under the chairmanship of Jonas R. Rappeport, M.D. It has completed a fourth draft of a position statement that has been distributed to the Council, Reference Committee, the Committee on Psychiatry and the Law, and the Assembly for criticism and suggestions in the hope of soon having a final statement for publication. A session on this topic at the 1975 APA annual meeting is also under consideration.

The *Task Force on Religion and Psychiatry*, Abraham N. Franzblau, M.D., chairman, has completed its survey of APA members who have indicated that they provide services to religious institutions as well as the survey of 400 nonproviders for comparison. The findings of the task force were presented at the

1974 APA annual meeting, and a manuscript, "Report and Interpretations of the Survey of Providers of Psychiatric Services to Religious Institutions," is currently being reviewed by Council for potential publication.

This task force is being continued for two years in order to conduct a survey of the institutions that use psychiatric services to inquire about their evaluation of the effectiveness of these services and of their needs.

The Council on Internal Organization

MILTON GREENBLATT, M.D., CHAIRMAN

DURING THE PAST YEAR, the *Council on Internal Organization* welcomed a new member, Dr. Robert O. Pasnau, who was also appointed as vice-chairman of the Council. The following is a summary of the activities of the Council as reflected in the business discussed and negotiated during the course of the fall committee meetings in Washington, D.C., in October 1974.

The *Committee of Residents*, James M. Stevenson, M.D., chairman, had a very successful fall annual meeting, with the following topics discussed and actions taken:

1. Two forum-type programs have been submitted to the Program Committee for the 1975 APA annual meeting in Anaheim—one on the interface between psychiatric residents and APA affairs and another on the relationship between the American Psychiatric Association and the American Board of Psychiatry and Neurology.
2. Suggestions for more complete *Psychiatric News* coverage of the activities of residents were made. The staff of *Psychiatric News* will cooperate. However, a suggestion made to develop a special column devoted to residents was not considered feasible by the editor of *Psychiatric News*.
3. A need for greater participation of residents in the affairs of APA at the district branch level was stressed.
4. It was noted that 90 percent of residents planned to apply for examination by the American Board of Psychiatry and Neurology.
5. The Committee of Residents endorsed provisional membership for residents as vital to its continued functioning. There were, however, regrettable delays in processing of membership applications.
6. The Key Conference on the organization of APA will include at least seven residents.
7. Considerable interest was expressed in an "administrative psychiatry elective" at APA headquarters in Washington, D.C. A formal request in this respect will be rendered in the immediate future.
8. It is important that training directors impart information about APA to their trainees.

The Herlitz Company reported on the status of technical and scientific exhibits at the annual meeting and on advertisement in *The American Journal of Psychiatry, Psychiatric News*, and *Hospital & Community Psychiatry*.

With regard to the APA annual meeting in Detroit, there were 112 technical exhibits, 24 scientific exhibits, and 11 institutional exhibits. Gross income from technical and scientific exhibits was $74,575 and from institutional exhibits, $4,400. This represents a marked improvement over the Hawaii convention, which failed to attract many exhibitors because of distance. There has been a general upward slope in gross income from these exhibits. Institutional exhibits are a relatively new source of revenue. At the Institute on Hospital & Community Psychiatry in Denver, 31 technical and scientific exhibits grossed about $17,000.

General advertising in *The American Journal of Psychiatry, Psychiatric News*, and *Hospital & Community Psychiatry* grossed over 1 million dollars last year, with growth of revenues from these sources noted on a year-by-year basis despite increased competition, increased costs of sales promotion, and overall decrease in the vitality of the general economy.

The Council voted to continue to employ Herlitz and to require annual reports from Herlitz to the Council on Internal Organization.

The *Committee on Member Insurance and Retirement Plans*, Chester Trent, M.D., chairman, devoted the entire day to discussion of our professional liability program underwritten by Chubb & Sons and administered by the Joseph A. Britton Agency. Approximately 2,800 insured members were in the program as of September 1, 1974. Losses to date have been minimal. Losses and claims in malpractice, however, are slow in being reported. Because of serious losses from malpractice in the United States, and as a result of inflation and stock market regression, insurance companies' rates for professional liability have increased. The broker, therefore, proposes rate changes in most states varying from a 236 percent increase in South Dakota to a decrease of 10 percent in southern California. These changes were thoroughly discussed by the committee, which formally recommended their adoption. The overall premium increase is estimated to range from 32 to 39 percent across the nation.

The Council voted approval of the 32 to 39 percent malpractice insurance premium increase, but the Reference Committee recommended this be discussed at the meeting in January 1975. The appropriateness of abolishing the $150,000 coverage as too low was discussed next. The committee has decided against abolition of this coverage because some APA members, although employed in government service, may desire additional legal protection that normally would be afforded under low coverage. It was also discussed and recommended that each APA member should obtain maximum coverage whenever possible because inflation will affect claims that may be adjudicated up to seven years following an alleged incident of malpractice. The Council voted that no mandatory limit be set on the amount of insurance coverage sought by our members.

The Council next considered reports relating to the APA retirement fund and the recommendations of the Board of Trustees, voting that there be an annual independent audit of the retirement fund. They also voted that the Committee on Member Insurance and Retirement Plans proceed to explore coverage for the committee and the Trustees of APA Retirement Plans above and beyond that normally provided by APA. They were also urged to study the needs and requirements for further insurance by other components of APA that may have contingent liability in these matters.

In discussions of the accident and health program for APA staff, the district branches, and employees of the members of APA, a sharp difference of opinion was voiced between the Insurance Committee and the Task Force on Confidentiality as to how much information ought to be divulged by applicants for insurance. The Council then voted to endorse the present negotiations going on between insurance carriers and the Committee on Member Insurance and Retirement Plans toward developing a model which would take into account, as far as possible, appropriate requirements for confidentiality.

The *Committee on Conventions*, Alexander Simon, M.D., chairman, gave a report on the 1975 annual meeting at Anaheim. A placement service will be organized and operated at the 1975 annual meeting for the purpose of assisting those who are looking for jobs and those desiring to recruit employees. They voted that the Executive Committee be alerted to the fact that insufficient rooms would be available to accommodate members desiring to attend the business session of the annual meeting. Registration must precede the business session. The legality of a business session preceding the general convention should be explored with the Constitutional Committee.

At its meeting in October 1974, the Reference Committee voted to recommend to the Board of Trustees that a Subcommittee of the Committee on Conventions be appointed to develop standards and guidelines of technical exhibits and to review applications from exhibitors.

The *Task Force on Interface Between Industry and Psychiatry*, Harvey J. Tompkins, M.D., chairman, discussed the broad issues pertaining to the nature and type of subsidies now being given to APA activities and to APA members by pharmaceutical companies. The Southern California Psychiatric Society has taken the position that no subsidies be accepted to finance either programs, journals, or presidential activities of APA. The task force appointed by the Council under Dr. Tompkins, which will include Assembly representatives among its members, requested time to study all current practices regarding subsidization, including how presidents' funds are handled, procedures regarding advertisements in periodicals and journals, and support for conventions, district branches, committees of APA, and departments of psychiatry. The Medical Director indicated that APA staff will assist this task force with basic information needed to develop its final recommendations. Advice concerning legal implications relating to accepting gratuities, subsidies, and gifts will be sought from counsel.

The *Institute on Hospital & Community Psychiatry Program Committee*, W. Edward McGough, M.D., chairman, reported that the Institute at Denver registered 1,160 people. Income was $65,000 and expenditures, $55,000. The theme of the Institute concerned the merging of the many functions contributing to a total mental health care system. The program was divided into plenary meetings, small group discussions, and topically oriented sessions. Thirteen affiliated organizations met before, during, or after the Institute. The administrators and volunteers had very large meetings. The fall meetings of three area councils were also scheduled at this time. Altogether this was a most successful Institute.

The *Subcommittee on Planning and Priorities for the Manpower Division*, Jack Wolford, M.D., chairman, recommended that a new task force be formed on manpower because 1) APA needs better control of its information, 2) many special studies are needed, 3) decisions on scope of the work, relationship to the Membership Committee, and whether or not we should include allied health manpower must be made in giving direction to such a program. The Reference Committee referred back to the Council for further study the specific charge and time limit for a component to serve in an advisory capacity to APA Division of Manpower and suggested an Assembly representative to serve on such a component. The Council voted that a Task Force on Manpower Problems be appointed by the Council chairman.

The *Subcommittee on Establishing a National Council on Television and Film Consultations*, Henry Laughlin, M.D., chairman, in its deliberations, identified a probable need for the formation of a high-level, sophisticated consultation body to give advice and guidance to all individuals, either within APA or outside, who are preparing films involving the subjects of mental stress and emotional disorder. The Council voted that the chairman of this committee bring together interested parties: the chairman of the Public Information Committee, the APA Medical Director, the Office of Public Affairs, media representatives, Assembly representatives, and residents to clarify this area and to develop specific recommendations for the future.

The Council reviewed material available to it in questionnaire form covering the operations of 54 components of APA. Thirteen councils and components did not respond. Preliminary analysis revealed a great variation in efficiency of functioning of the various components. In many instances charges to councils were general and nonspecific. Goals were not stressed, nor was a timetable for completion of business specified. Consultation with chairmen was not always provided by the appointing officer before making appointments to a particular component. On at least several occasions members who had resigned or could not attend were not replaced in reasonable time.

It was felt that the work of the various councils and components could well be organized under a management-by-objective concept. A meeting will soon be held by the subcommittee appointed by the Reference Committee to handle analysis of the survey and to recommend further steps.

The Council discussed the advisability of calling on an outside consultant to advise and educate members responsible for effective functioning of committees and for optimum use of APA resources on principles of management by objective.

The *Program Committee*, H. Keith H. Brodie, M.D., chairman, gave a report on the official program planned for the annual meeting in Anaheim. The possibility of termination of drug companies' contributions to support the activities of the Program Committee was also discussed. The Council voted that 1) further exploration of use of limited-attendance workshops by the Program Committee would be encouraged and 2) any decrease of funds arising from termination of pharmaceutical house contributions be covered by APA for that year.

The *Public Information Committee*, Arnold Werner, M.D., chairman, suggested changes in the *Operations Manual* that would inform members it is available to any component of APA for consultation and advice. *A Psychiatric Glossary* is in galley form. Basic Books is interested in producing a hardcover edition.

The committee discussed the proposal of Lederle Laboratories to produce a series of 60-second TV spot announcements on mental health and reviewed a sample. There will be no mention of Lederle Laboratories, of special drugs, or of medication; the

Public Information Committee will have editorial control over wording of the announcement. The Council voted that the public service announcement be approved. The Council also voted to endorse the development of a Benjamin Rush film commemorating the Bicentennial Celebration, but cautioned that funds not be voted by APA to anyone likely to reap financial profit from such a venture. Legal advice should be sought in this connection where necessary. The quality and appropriateness of certain exhibits at the 1974 annual meeting led to a discussion on better screening methods. It was recommended that Dr. Froelich of the Subcommittee on Scientific Exhibits be contacted for his views. Following a discussion of distortion in the Marcus Welby TV program on homosexuality, the advisability of a consultation service for long-range planning concerning scripts and programs presented to the public was considered.

Reports of the *Vestermark Prize Board*, Louis A. Gottschalk, M.D., chairman, the *Manfred S. Guttmacher Award Board*, Jonas R. Rappeport, M.D., chairman, and the *Isaac Ray Award Board*, John K. Torrens, M.D., chairman, were received with thanks.

The Council on Emerging Issues

EDWARD T. AUER, M.D., CHAIRMAN

THE COUNCIL ON EMERGING ISSUES met three times during the past year to consider emerging areas of concern to the profession and APA. Its task forces have been working on their assignments throughout this period.

The Council approved the report of the *Task Force on Psychohistory* in January 1975. The report should be published by late spring. This task force, chaired by Charles Hofling, M.D., has produced a comprehensive discussion of many of the problems and the ethics involved in researching and writing psychohistorical and/or psychobiographical works and psychiatric profiles.

The members of the *Task Force on Women in Psychiatry*, Nancy Roeske, M.D., chairwoman, felt that the charges of examining the role of women in psychiatry and the role of psychiatry in the lives of women are ongoing concerns which are just beginning to be considered in depth. The recommendation was made by the task force, seconded by the Council, and approved by the Board of Trustees that a Committee on Women be established in the Council on National Affairs.

The *Task Force on Psychiatric Involvement in Family Planning*, Eugene B. Brody, M.D., chairman, has thus far been unable to find outside support for a Conference on Psychosocial Aspects of Family Planning.

The *Task Force To Define Mental Illness and "What Is a Psychiatrist?,"* chaired by Morton Reiser, M.D., submitted a draft report to the Council in January 1975. The Council members think that the draft report should be reviewed by the members of the Conference on Education of Psychiatrists to be held in June 1975 and by other selected components. The life of the task force will be extended to accommodate these additional inputs.

Refinement of a draft report on psychosurgery is in process by the *Task Force on Psychosurgery*, John Donnelly, M.D., chairman, and its final report is expected to be ready by the fall of 1975.

Several issues have been discussed by the Council that are of continuing concern. The recent changes in the economy and the related mental health problems are being called to the attention of other APA components. For example, it is recommended that the Council on Mental Health Services consider the impact of the adverse economic situation of the country as one aspect of its ongoing concern with the delivery of mental health services. Also, the Council recommends that the Reference Committee consider an appropriate way in which psychiatrists might be alerted to the effects of psychosocial stresses associated with financial problems on the health of our senior citizens.

Attention was focused on mental health problems of the family. Because the theme of the 1975 annual meeting is "Focus on the Family," it is suggested that a component be established in APA concerned exclusively with the family.

The Council has asked the Eastern Missouri District Branch to appoint a task force to write a history of recent antipsychiatry activities of the Church of Scientology in Missouri. These activities have resulted in major impediments to research activities and investigations of specific charges against the public and private sectors of psychiatry by the Governor of Missouri.

An informal survey of directors of training programs, chairmen of departments of psychiatry, and chiefs of staff of service facilities is being undertaken by the Council to ascertain current attitudes, policies, and practices regarding hiring and training of homosexual persons in psychiatry. This survey is part of an ongoing concern with the civil rights of homosexuals; the results should be available in April 1975.

In the course of the year, the Council prepared a statement that was publicized in the form of a press release by the Association praising President Ford's amnesty program as a "first step" in the right direction. The Council continues to be concerned with what further steps may be taken to liberalize the amnesty program and is keeping in touch with developments.

The Council has also discussed at some length, but without recommending specific actions at this time, such problem areas as the inadequacy of aftercare facilities for discharged public mental hospital patients, ways and means of defining quality psychiatric care, questions of inadequate standards of treatment and care in some community mental health programs, the psychological effects of problems of malnutrition and hunger among deprived populations, especially on early growth and development, the question of whether and how the Association could support colleagues in other countries deprived of their human rights, and the impact on psychiatry of civil rights legislation.

The Assembly of District Branches

FUNDS REQUIRED FOR the operation of the Assembly are provided from the Treasury of APA, expended in accordance with the budget prepared by the *Budget Committee*, and approved by the Assembly and the Board of Trustees. During the past year funds were approved for presidents-elect to attend a one-day orientation meeting at APA headquarters at the time of the fall Assembly, a highly successful undertaking that may become a permanent part of the budget. Another important addition in the current budget was an appropriation for travel expense of legislative representatives to meet as a group during the time of the fall and spring area council meetings. In December 1974 the Board approved a recommendation to pay travel expenses for alternate delegates to attend the fall Assembly. It was considered important that they become thoroughly familiar with procedures and activities of the Assembly prior to assuming responsibilities as delegates.

The *Committee on Divisional Meetings* reported that the Area II divisional meeting held on March 15 to 16, 1974, was a tremendous success, with a total of 692 persons officially registered (not including spouses, guests, speakers, or the press). Psychiatrists accounted for 76 percent of the registrants, the remainder being other physicians, psychologists, social workers, nurses, and a large number of interested laymen and state legislators. Areas II and VI questioned the sources of financial support for such gatherings, the ethics of advertising in general, and the relationship between pharmaceutical houses and health professions in particular. The issue, which is very complicated, was discussed in the Assembly. The committee also suggested that some thought be given to developing liaison with the APA Program Committee about using the overflow of material they cannot accept each year since it is sometimes difficult to develop high quality divisional meeting programs. The next scheduled divisional meeting will be held in New York City on November 6 to 7, 1976. Area VI had its first combined annual meeting recently and questioned whether it can reclassify this meeting as a divisional meeting because of its present nature (attendance, its scientific content, etc.); however, divisional meetings are clearly defined as Association meetings, and district branch annual meetings are local in nature.

The *Committee on Membership* has continued its interest in the development of "provisional" membership in the Association. Although the APA Membership Committee has opposed the establishment of a separate category as being an unnecessary administrative problem, the APA committees and the Assembly committees have now agreed that this matter be referred to the Committee on Constitution and By-Laws to develop the necessary constitutional amendment for implementation at the earliest possible time. There has been concern about the increase in members-at-large; however, through the concerted efforts of the Membership Division, Manpower Research and Development, and the Assembly of District Branches, the loopholes are gradually being closed. District branches have been urged to recruit the "illegal" member-at-large (members who had prior district branch membership but presently do not belong to a branch). Currently, a question has arisen concerning the requirement that a member must join a district branch (a business league) in order to qualify for membership in APA (a scientific and educational organization). This relates to the tax-exempt status of the branches in relation to APA as a whole. A survey to show the present tax-exempt status of district branches will be studied by the Board of Trustees.

The *Committee on Planning and Development* has the primary responsibility to assess the present and future condition of the Assembly with particular reference to its internal structure and function, its relationship to the area councils and district branches, and its relationship to the other components and officers of the Association. During the past year the committee, along with the Task Force on Revision of the Procedural Code, made several recommendations concerning the legislative processes with the Association, namely, to spell out the relationship of the legislative leaders (presently known as the Ad Hoc Committee on the Legislative Network) and to better define the method of their selection, duties, and functions. The Assembly approved a proposed legislative commission to be under jurisdiction of the Assembly by inclusion in the Procedural Code. The Board has approved the commission; however, its placement and function within the mechanism of the Association has not been decided (this will probably be an item of discussion at the Key Conference). The question of creating additional areas within APA (the constitution provides for a maximum of 10 areas) was studied, and the committee recommended no changes at this time. Ultimately this problem was referred to the Key Conference for further study. The committee studied the relationship between the professions of law and psychiatry and recommended that the Assembly and the Board work vigorously to bring the top leaders of each group together in an attempt to work through some of the areas of conflict that are beginning to greatly affect the care, treatment, and rehabilitation of the mentally ill.

The chairman of the *Committee on Public Information* is the Assembly liaison member on the APA Committee on Public Information and reports to the Assembly items of interest and/or action. The main direction of the committee at the present time is to raise the consciousness of the membership about the image of psychiatry. There will be continued attempts to inform the public on what psychiatry is all about and on our concern for patients and patient care. More and more of what is becoming public information has really concerned itself with feeding information to the various legislators and legislatures throughout the states. The current issues having the highest priority seem to be confidentiality and privilege, patients' right to treatment and to a voice in choosing among alternatives, setting standards for quality care, ensuring continuity of competence of the psychiatrist and other care givers through such methods as peer review and continuing education, and gaining equal coverage for the mentally ill under national health insurance.

The *Task Force on Formulation of Policy Regarding Membership Participation* was appointed to determine whether the APA governing bodies as now constituted and elected are in fact representative of the individual members of the Association. It studied, in depth, representation at the local level (delegates to the Assembly), representation at the area council level and the role of this body in the Association as a whole, and the present system at the national level as opposed to the development of alternative systems that may resolve present dissatisfaction (bicameral or an executive and legislative branch with a clear separation of powers). A concise report of the task force was accepted by the Assembly for referral to the Key Conference.

The *Task Force on Delivery of Mental Health Services* continued to discuss pertinent issues concerned with the impending national health insurance and the involvement of individuals

and district branches for adequate input. The primary interest of the task force at the present time is the financing of mental health care and the development of an APA position statement concerning national health insurance. Some of the major issues discussed by this task force were PSRO matters that merit continuing concern and monitoring by the Assembly and inappropriate insurance utilization. The task force also expressed concern that rigid implementation of programs to control costs might compromise quality of care and impede the development of improved or new methods of treatment. The task force reviewed the regulations of health maintenance organizations (HMOs) and has urged psychiatrists to become involved in individual HMOs and to use their influence to develop health service benefits covering inpatient psychiatric treatment and expanded outpatient mental health services. It also recommended that APA appoint a task force on HMOs to recommend ways of developing more adequate psychiatric services in HMOs, both nationally as legislative requirements and locally as supplemental services in individual plans.

The *Task Force on Revision of the Procedural Code* expressed concern that provisions in the Procedural Code regarding voting strength in the Assembly may disenfranchise members (this problem also concerns those involved in the development of area council procedural codes). The task force during the past year developed an amendment for the regular election of the new Area VII Trustee after the Assembly approved the formation of a new Area VI, the California district branches. In conjunction with the Committee on Planning and Development the task force developed an amendment to include the proposed legislative commission under the Procedural Code, although that body would in reality be required to report to both the Assembly and the Board of Trustees. The amendment essentially spelled out the composition of the commission and its function. The Board has approved the appointment of the commission but did not indicate the body to which it will be directly responsible.

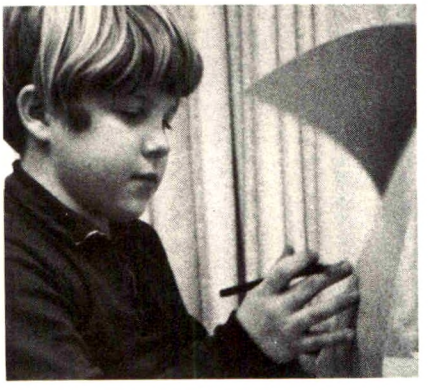
In addition, at the request of the APA Task Force on Confidentiality, a committee had proposed a system of coding insurance information in the area of mental disorders. This was discussed by the Assembly in November and a recommendation was approved to establish a task force to plan and implement the program. A major part of the plan would be to have two district branches to do the study, but there was some question about the funding of the project. A member of the Task Force on Confidentiality was asked to explore this further with the Health Insurance Association of America, and a feasible plan was suggested to field test the proposed code system in California, Connecticut, and Wisconsin if indicated. The Assembly Executive Committee approved a recommendation to 1) send the proposal to the three district branches to ask their estimate of the cost, 2) proceed to appoint a task force made up largely of members from the district branches involved, and 3) present this proposal to the Board of Trustees for their approval and request funding for the project.

As an adjunct in a treatment program for children with MBD...

ABBOTT INTRODUCES

Cylert®

(pemoline) C IV



An effective aid for transforming undirected hyperkinetic behavior into purposeful activity

Among the noteworthy properties of Cylert (pemoline)

- It is structurally different from the amphetamines and methylphenidate.
- It has shown no evidence of producing tolerance with long-term administration.
- It is taken but once daily, sparing the child the need of mid-day doses at school.
- It has produced significant improvement in behavior according to ratings by physicians, parents and teachers.
- It has shown minimal cardiovascular effects, with little or no effect on pulse or blood pressure.

ABBOTT

Please see last page of this advertisement for Prescribing Information.

The place for Cylert (pemoline) in a treatment program for MBD

The adjunctive use of Cylert
As an adjunct in an overall treatment program, Cylert can increase attention span in the hyperkinetic child and enable him to gain greater control over his actions.

A child successfully treated may show marked improvement in concentration and become more responsive to instruction and counseling.

Typically, the parent or teacher will report fewer emotional upsets and temper tantrums, and far less "squirming" and disruptive motion.

As his attention span improves, the child has less tendency to leave things unfinished. Often in directed activities such as handwriting or drawing exercises, there will be visible improvement in organization.

Cylert in itself will not "enhance learning" or resolve difficult behavioral problems. But it can enable the child—perhaps for the first time—to channel *undirected* hyperkinetic behavior into purposeful activity.

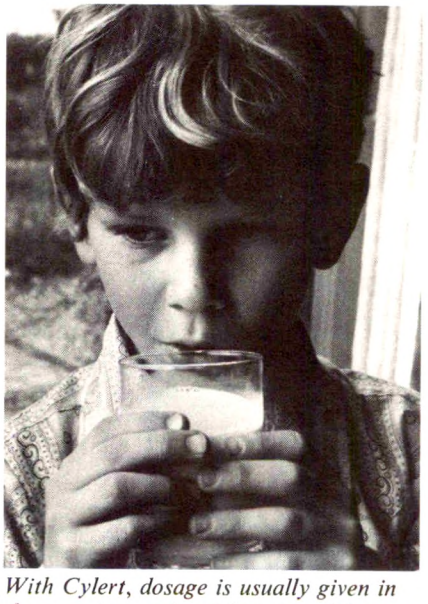
How Cylert differs from other agents
Cylert is a mild central nervous system stimulant which is structurally different from the amphetamines and methylphenidate.

Onset of action
Using the recommended schedule of dose titration, significant benefits may not be seen until the third or fourth week of drug therapy. Side effects may be seen prior to optimum clinical results.

Dosage is taken only once daily
Cylert is usually administered once daily, in the morning.

The importance of single daily dose administration
Among the benefits:

The parent maintains control of medication; there is no need for the child to carry drugs to school.



With Cylert, dosage is usually given in the morning, at breakfast time. There is no need to carry medication to school.

The child is spared the embarrassment of having to "take his medicine" while at school.

There is no continuing reminder to his classmates that he is "different".

There is no need for a nurse or teacher to supervise the taking of a mid-day dose.

Finally, there is no interruption in therapy caused by missed, forgotten or delayed doses.

Cylert, alone among CNS stimulants used for treatment of hyperkinetic behavior, is inherently long-acting, permitting once-a-day dosage.

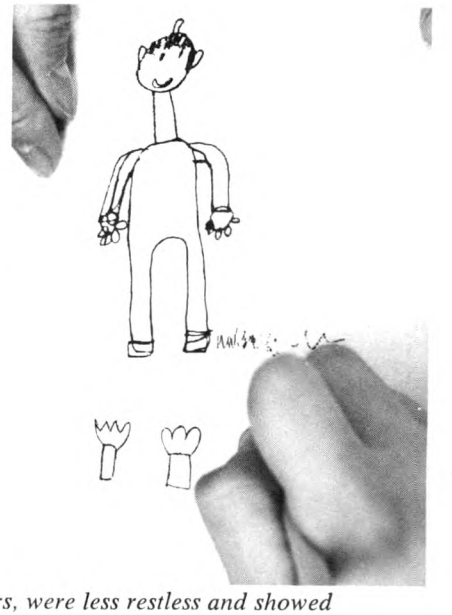
When NOT to use Cylert
Cylert should not be used for (and will not be effective in) simple cases of overactivity in school-age children.

Neither should it be used in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

The physician should rely on a complete history of the child and a thorough description of symptoms from both parents and teacher before postulating a diagnosis of MBD.

Multi-clinic study[1,2] shows significant improvement in children receiving Cylert (pemoline)



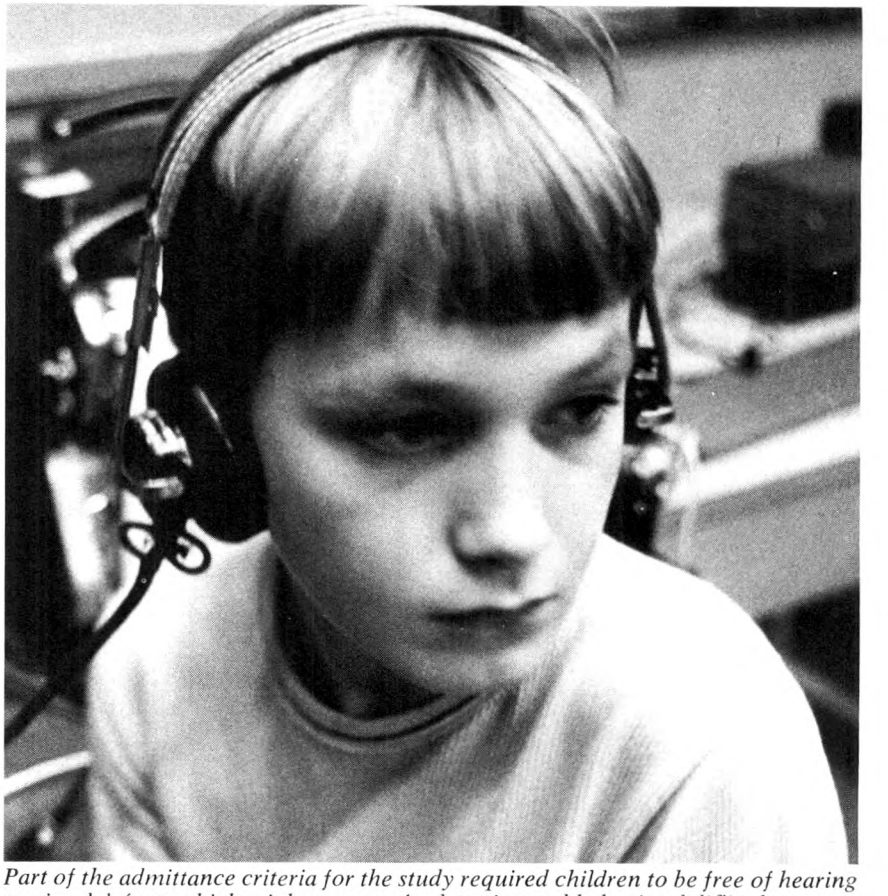


Parents and teachers reported that MBD children on Cylert got along better with others, were less restless and showed less tendency to leave things unfinished. Above: an MBD child (not yet on Cylert) is being given the Goodenough-Harris Draw-a-Person test.

In a double-blind, placebo-controlled study, 238 children, ages six to 12, were treated over a nine week period. *Global (overall) ratings by teachers, parents and physicians were performed at weeks 0, 3, 6 and 9. Parent and teacher ratings showed that Cylert effected significant improvement, compared with placebo, beginning at week three. Physician ratings showed significant improvement beginning at week six.*

Psychological tests

Children on Cylert had significantly higher scores than those on placebo on many of the tests, including the full scale Wechsler Intelligence Scale for Children (WISC) and its Performance IQ Sub-component; the Wide Range Achievement Test (WRAT) (reading and arithmetic); and the Lincoln-Oseretsky Motor Performance Test Factor II.



Part of the admittance criteria for the study required children to be free of hearing or visual defects which might account for learning and behavioral difficulty.

1. Conners, C. K., ed., *Clinical Use of Stimulant Drugs in Children*, Excerpta Medica, 1974, p. 98. 2. Page, J. G., et al., J. Learning Disabilities, 7:498, Oct., 1974.

Please see last page of this advertisement for Prescribing Information.

The parameters of safety of Cylert (pemoline)

FROM MULTI-CLINIC STUDIES (9 WEEKS); SAFETY DATA COLLECTED ON 407 PATIENTS

Parameters studied:

Blood pressure	No difference between Cylert and placebo groups
Pulse	No difference between Cylert and placebo groups
Laboratory tests	No difference between Cylert and placebo groups
Neurological status	No difference between Cylert and placebo groups

Other criteria:

Adverse reactions	Insomnia and anorexia most frequently seen side effects and often improved with continuation of treatment or reduction of dosage. (For other side effects, see Prescribing Information on facing page.)
Weight loss	Mean weight loss of 1.5 lbs. was demonstrated in Cylert group during early weeks of treatment; by 3-6 months, the children returned to the normal weight-curve for their age group.

FROM ADDITIONAL STUDIES (LONG-TERM) ON CYLERT (UP TO TWO YEARS AND CONTINUING)

Parameters reviewed:

Mean dosage	Essentially unchanged on mg./kg. basis from original effective dosage.
Blood pressure and pulse rates	Normal in all patients.
Laboratory examination	Mild to moderate increase in transaminase (SGOT and SGPT) levels in a few patients (no clinical symptoms); levels returned to normal on withdrawal of medication. No clinically significant abnormalities in the other tests.

Cylert (pemoline)



Prescribing Information

Description: Cylert (pemoline) is a white, tasteless, odorless powder which is relatively insoluble (less than 1 mg/ml) in water, chloroform, ether, acetone, and benzene. In 95% ethyl alcohol, the solubility of pemoline is 2.2 mg/ml.

Actions: Cylert (pemoline) is a central nervous system stimulant. The pharmacologic activity of pemoline is similar to that of other known stimulants but with minimal sympathomimetic effects. Pemoline is structurally dissimilar from the amphetamines and methylphenidate. Although the exact mode of pharmacodynamic action is undetermined in man, pemoline has been reported to increase the rate of synthesis of dopamine in rat brain.

In human subjects, Cylert produces peak blood levels within 2-4 hours. The serum half-life is approximately 12 hours. Multiple dose studies in adults at several dose levels indicate that serum levels plateau in approximately three days. Cylert and its metabolites are primarily excreted by the kidneys with approximately 75% of an oral dose appearing in the urine within a 24-hour period. Approximately 43% of pemoline is excreted unchanged. Metabolites include pemoline dione, conjugated pemoline and mandelic acid.

Cylert (pemoline) has a gradual onset of action in children with minimal brain dysfunction. Using the recommended schedule of dosage titration, significant clinical benefit may not be evident until the third or fourth week of drug administration.

Indications: MINIMAL BRAIN DYSFUNCTION IN CHILDREN—as adjunctive therapy to other remedial measures (psychological, educational, social).

Special Diagnostic Considerations:

Specific etiology of minimal brain dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis includes the use not only of medical but of psychological, educational, and social resources.

Characteristics commonly reported include: A chronic history of moderate to severe hyperactivity, short attention span, distractibility, emotional lability, and impulsivity. Nonlocalizing (soft) neurological signs, learning disability, and abnormal EEG may or may not be present. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. In the primary therapy of MBD, appropriate educational placement is essential and psychosocial intervention is generally necessary. When these measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

Contraindication: Cylert (pemoline) is contraindicated in patients with known hypersensitivity or idiosyncrasy to the drug. (See PRECAUTIONS)

Warnings: Cylert is not recommended for children under six years of age since safety and efficacy in this age group have not yet been established.

Since Cylert (pemoline) and its metabolites are excreted primarily by the kidneys, caution should be observed in administering the drug to children with significantly impaired renal function.

Sufficient data on safety and efficacy of Cylert administration for periods beyond two years duration in children with minimal brain dysfunction are not yet available. Although a definite causal relationship has not been established, some temporary suppression of predicted growth pattern(i.e., weight and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored.

Drug Interactions: Interactions between Cylert and other drugs have not been studied in humans. As with most other drugs, concurrent administration with other agents, especially drugs with central nervous system activity, should be carefully monitored.

Usage in Pregnancy: Safety for use in pregnancy has not been established. Standard studies of fertility, teratology and reproduction were conducted in rats and rabbits. Daily oral doses of pemoline of 18.75 and 37.5 mg/kg beginning at conception produced no abnormalities in the fetuses and did not affect viability at birth. Further studies using similar dose levels with drug administration beginning 14 days before conception demonstrated an increased incidence of stillbirths in these animals.

Drug Dependence: Studies of the drug abuse potential of Cylert (pemoline) in primates have not demonstrated a potential for self-administration. However, the pharmacologic similarities between Cylert and other CNS stimulants with known abuse liability suggest that drug dependence of the stimulant type might occur. There have been isolated reports of transient psychotic symptoms in adults following long-term misuse of pemoline taken orally in excessive quantities. Therefore, caution should be observed in emotionally unstable patients considered to have a psychological potential for drug dependence.

Precautions: Delayed hypersensitivity reactions involving the liver have been reported in 1-2% of the patients receiving Cylert usually after several months of therapy. No clinical symptomatology has been observed, but mild to moderate increases in transaminase (SGOT and SGPT) levels have occurred in these cases. These effects appear to be completely reversible when drug treatment is discontinued. Transaminase levels should be determined periodically during therapy with Cylert to detect any such reactions.

Adverse Reactions: The most frequently reported adverse reaction with Cylert is insomnia. Insomnia has been observed prior to optimum therapeutic response and in the majority of cases was transient in nature or responded to dosage reduction. Anorexia with weight loss during the first few weeks of therapy has also been reported. With continuing therapy, a return to a normal weight curve usually occurred within three to six months. Other adverse reactions reported include stomachache, skin rash, irritability, mild depression, nausea, dizziness, headache, drowsiness, and hallucinations. Mild adverse reactions appearing early in treatment often remit with continuing therapy. If adverse reactions are of a significant or protracted nature, dosage reduction or discontinuation should be considered.

Dosage and Administration: Cylert (pemoline) is administered as a single oral dose each morning. The recommended starting dose is 37.5 mg per day. This daily dosage should be gradually increased at one week intervals using increments of 18.75 mg until the desired clinical response is obtained. The mean daily effective dose ranges from 56.25 to 75 mg per day. The maximum recommended daily dose of pemoline is 112.5 mg.

Clinical improvement with Cylert is gradual. Using the recommended schedule of dosage titration, significant benefit may not be evident until the third or fourth week of drug administration. Drug administration should be interrupted occasionally to determine if behavioral symptoms sufficient to require continuing therapy recur.

Overdosage: Cylert overdosage has been reported to produce symptoms of tachycardia, hallucinations, agitation, or restlessness. The treatment of acute massive overdosage with pemoline is essentially the same as that for overdosage with any drug having CNS stimulatory effects. Management is largely symptomatic and may include induction of emesis, gastric lavage or other measures as appropriate.

How Supplied: Cylert (pemoline) is supplied as monogrammed, grooved tablets in three dosage strengths:

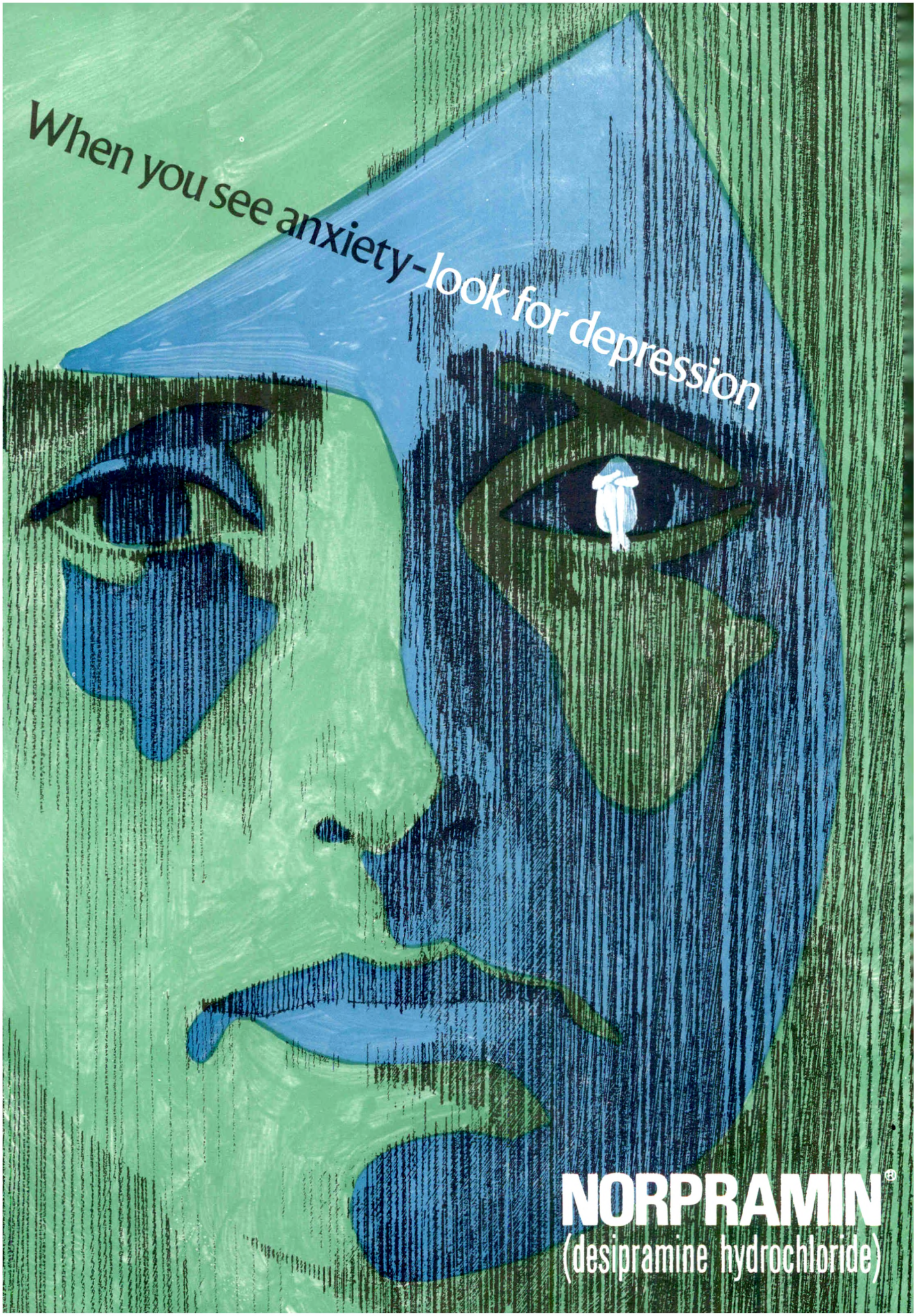
18.75 mg. tablets (yellow-colored) in bottles of 100 (**NDC** 0074-6025-13)

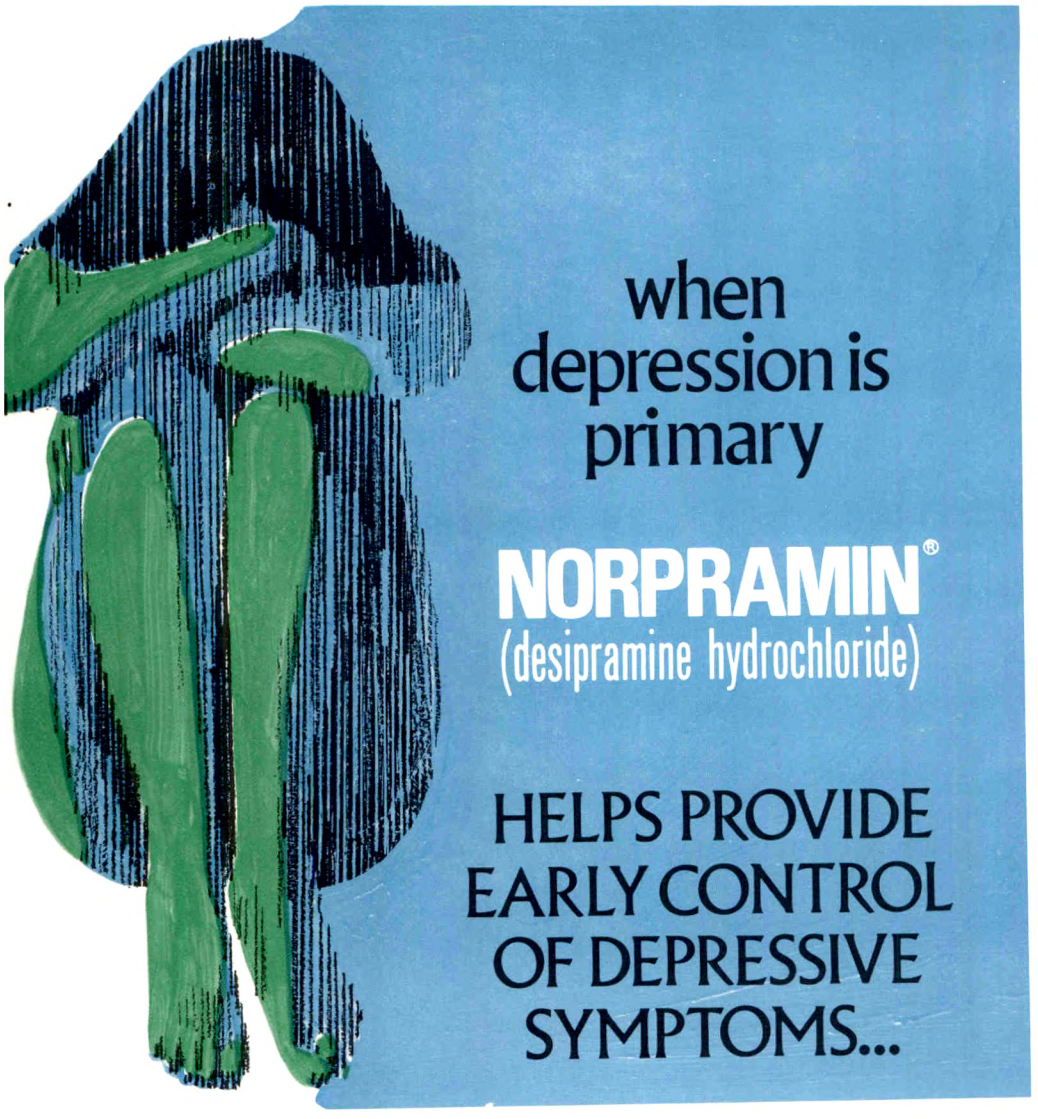
37.5 mg. tablets (orange-colored) in bottles of 100 (**NDC** 0074-6057-13)

75 mg. tablets (tan-colored) in bottles of 100 (**NDC** 0074-6073-13)

ABBOTT

504070


When you see anxiety-look for depression
NORPRAMIN®
(desipramine hydrochloride)



Anxiety is an invidious symptom. It feeds upon sickness, gnaws, grows and invades every cranny of psychic pathology adding intensity to torment. Anxiety as a symptom secondary to depression may be so dominant that it obscures the primary diagnosis. It may suggest treatment with tranquilizers which often help. But as the vampire of legend had to have a laurel stake driven through its heart to truly die, so anxiety secondary to depression will not cease to nibble and bite until an antidepressant eradicates the primary illness—and symptomatic anxiety starves

Norpramin® (desipramine hydrochloride) 25 mg. and 50 mg. tablets.

IN BRIEF:

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. If possible, dispense in child-resistant containers. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of phychosis in schizophrenic patients. Use cautiously with anticholinergic or sympathomimetic drugs. Response to alcoholic beverages may be exaggerated. In the concurrent administration of ECT and antidepressant drugs one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

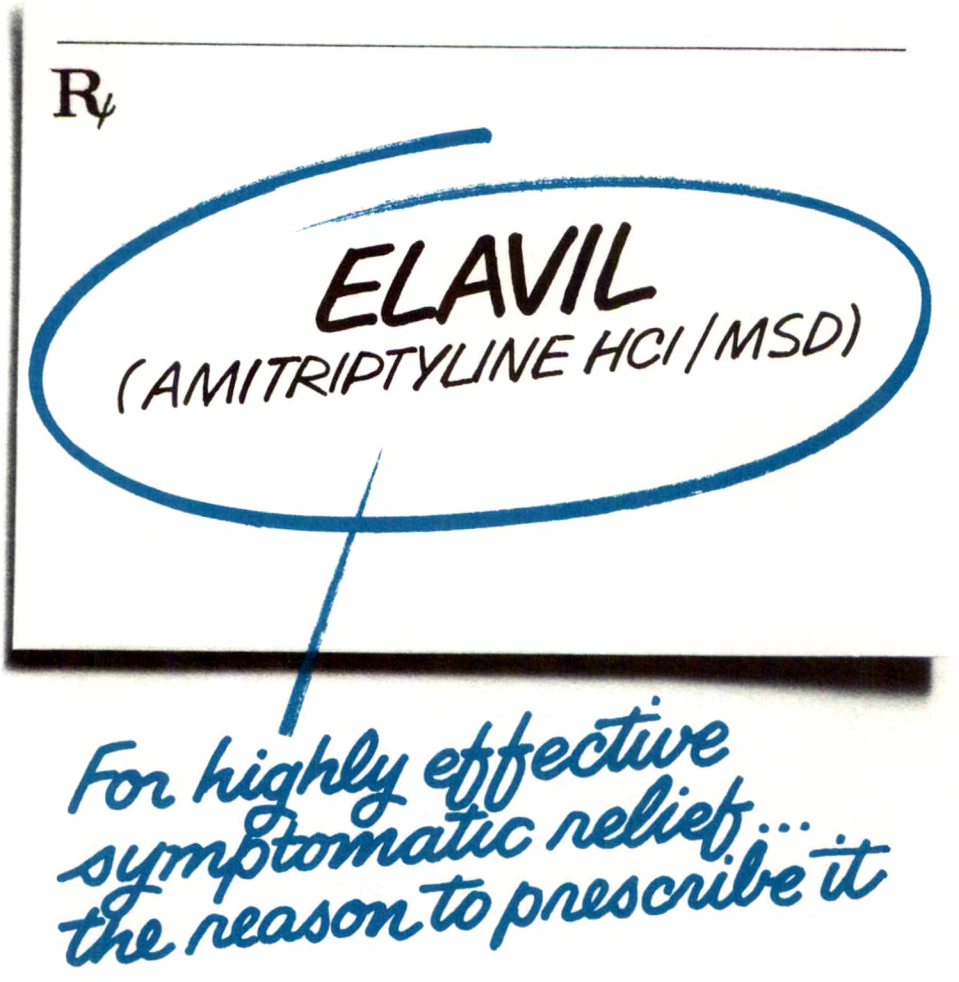
Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of phychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

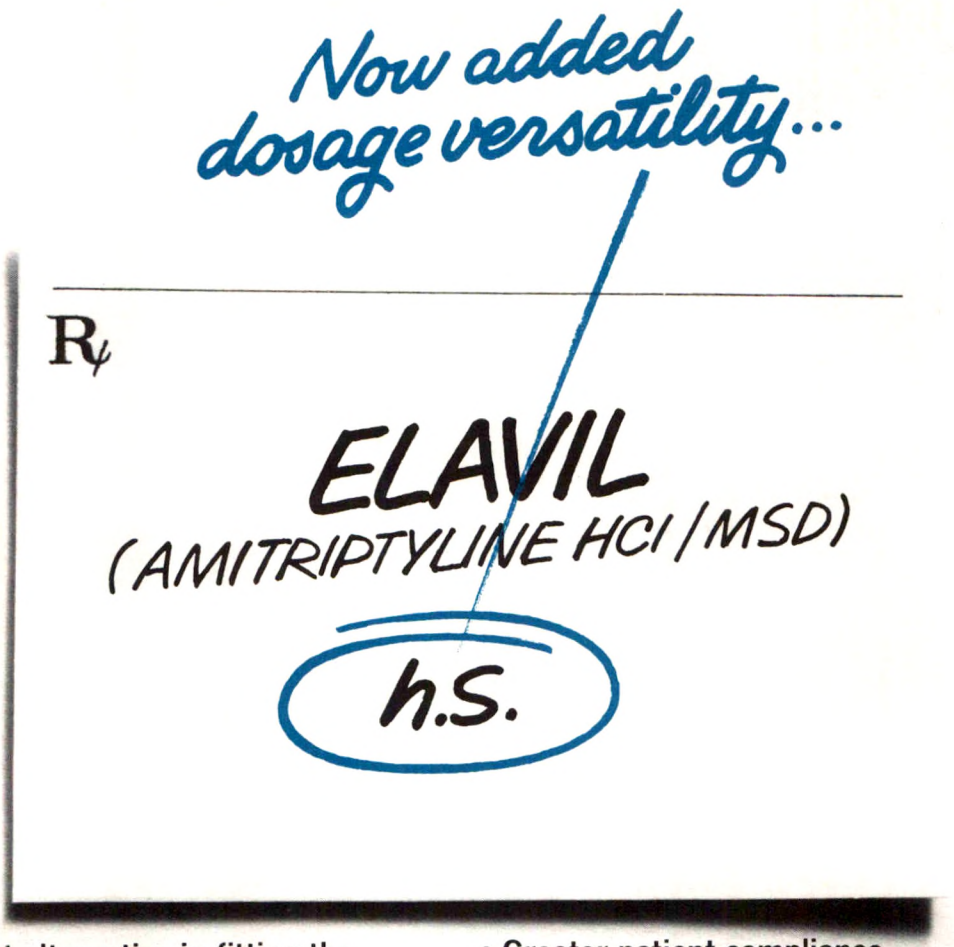
Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

LAKESIDE LABORATORIES
Division of Richardson-Merrell Inc.
Milwaukee, Wisconsin 53201

In the treatment of clinically significant depression...





- **An important alternative in fitting the medication to the patient's needs**

  Once-a-day dosage at bedtime is an appropriate way to start—and maintain—many patients on therapy. Of course, ELAVIL may be administered two, three, or four times as well as once a day. This dosage versatility allows prescribing precisely for the patient's needs.

- **Once-a-day dosage schedule for adult outpatients**

  Therapy should be initiated with 50 mg to 100 mg at bedtime. This may be increased by 25 or 50 mg added to the bedtime dose as necessary to a maximum daily dose of 150 mg. The usual maintenance dose is 50 to 100 mg a day given at bedtime, though in some patients, 40 mg per day is sufficient.

- **Greater patient compliance**

  The simplicity of once-a-day dosage at bedtime makes it easier for patients to adhere to a regimen—an especially important consideration in depressed patients whose self-motivation may be at a low ebb.

  Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

once a day at bedtime

Please see addendum on following page for other details of dosage and administration including divided daily doses, dosage in hospitalized patients, and dosage in elderly and adolescent patients.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

added dosage versatility in clinically significant depression

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

A new name in tricyclic antidepressants from A.H. Robins...

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brand of

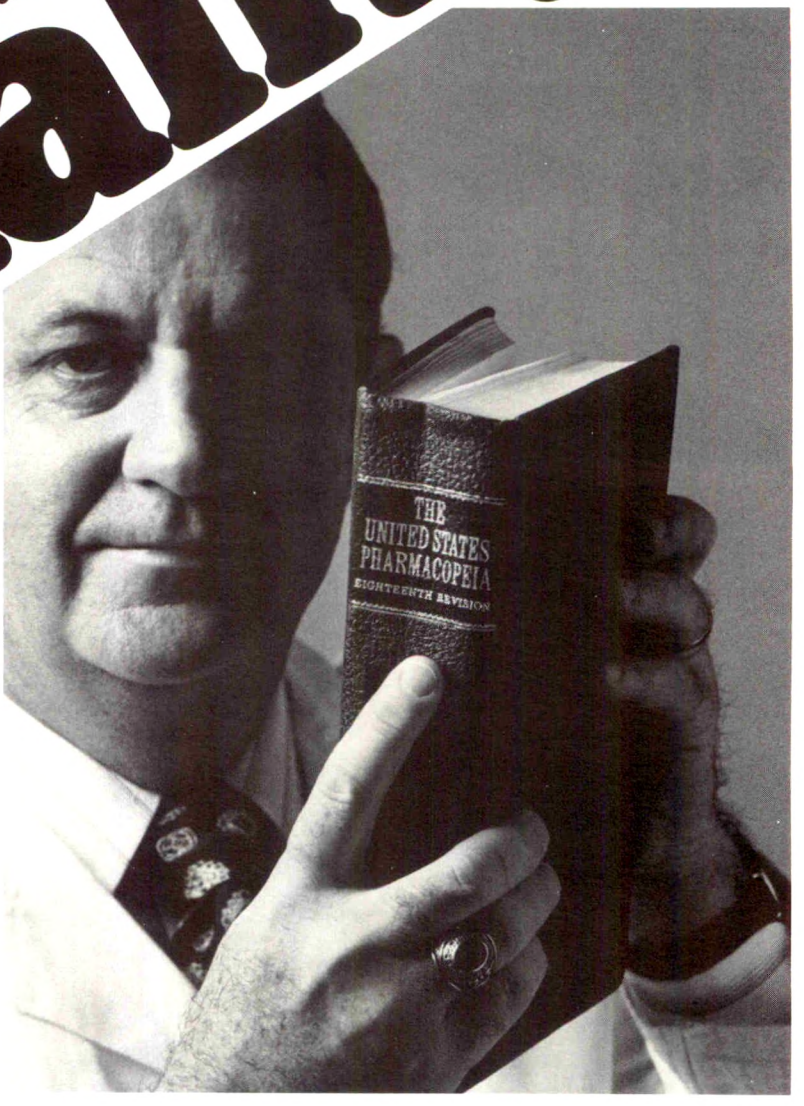
imipramine hydrochloride tablets, USP



and three reasons for remembering it...

...the first reason for remembering **Imavate®**

quality



Imavate tablets meet all the standards of identity, purity and strength stipulated in the United States Pharmacopeia (U.S.P.) for imipramine hydrochloride tablets.

ANTIDEPRESSANT

Imavate®

brand of

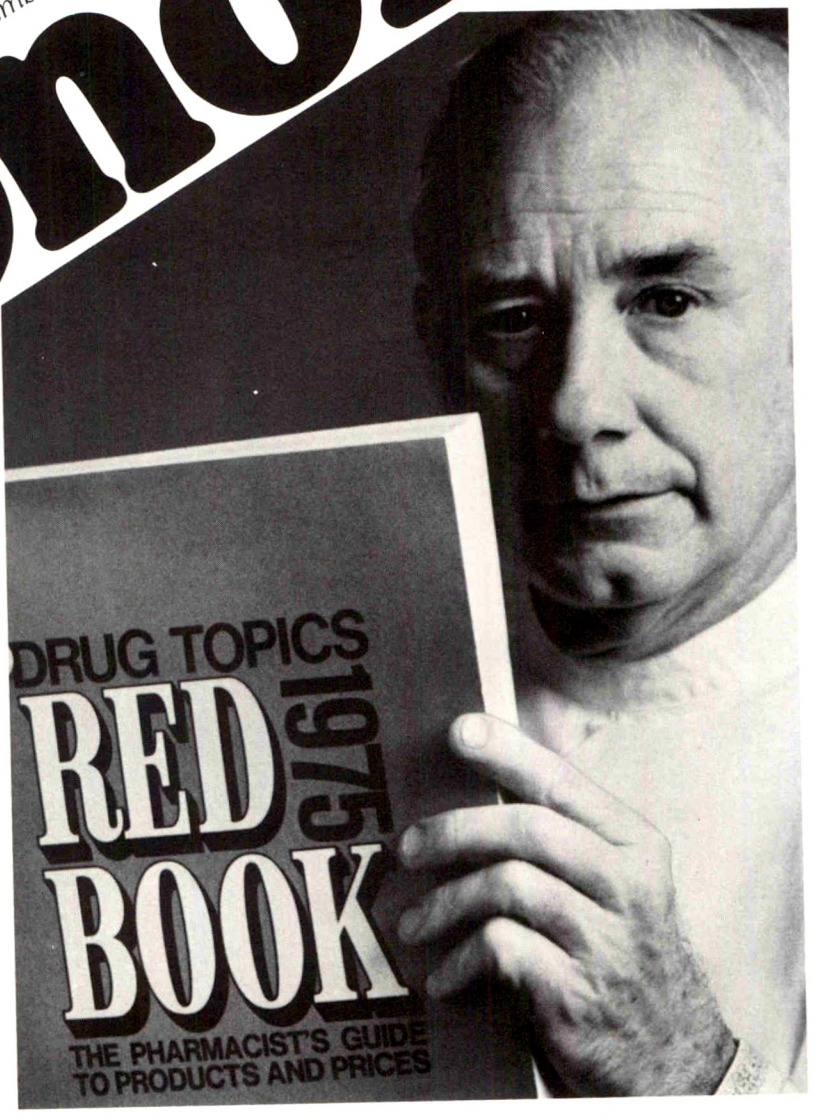
imipramine hydrochloride tablets, USP

10 mg, 25 mg, 50 mg

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economy

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The cost of Imavate Tablets to the pharmacist is 20-25% *lower* than the leading brand.

ANTIDEPRESSANT

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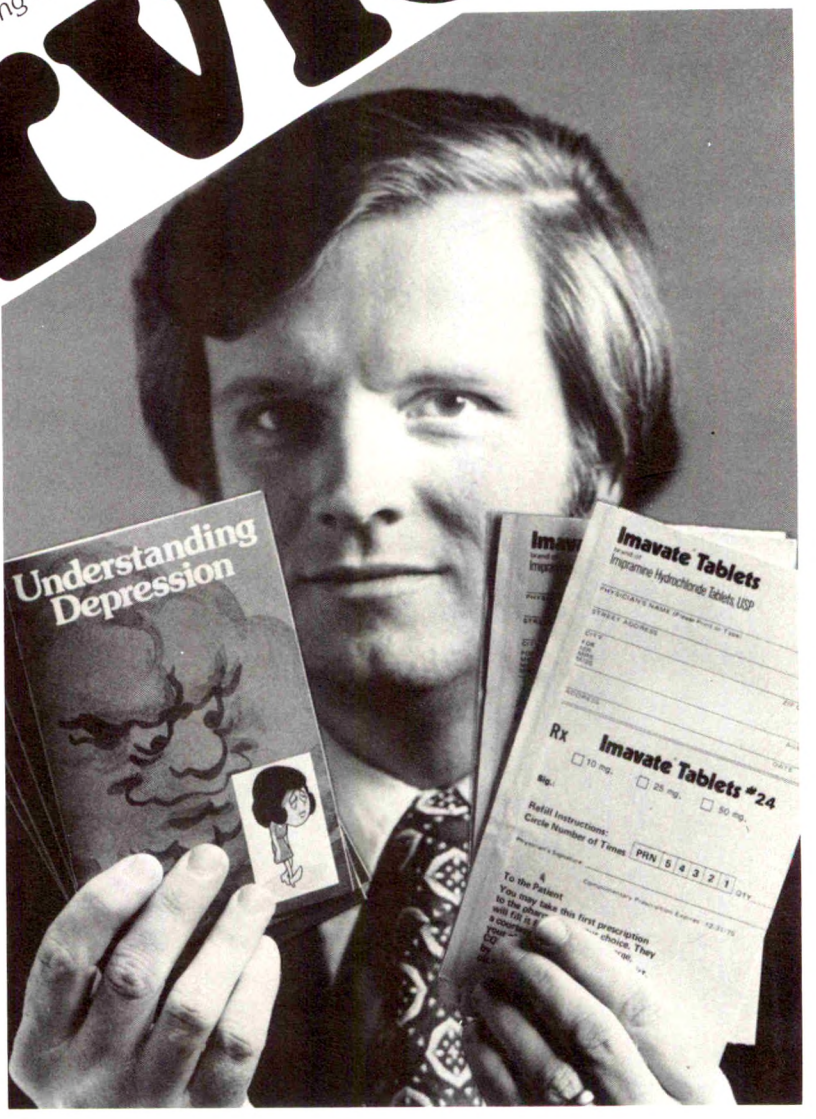
10 mg, 25 mg, 50 mg

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A63

...a third reason for remembering **Imavate®**

service



Your Robins Representative will provide you with a supply of *prepaid* prescriptions. These enable your patients to receive a week's therapy at no cost.

Also, for selected depressed patients this booklet "Understanding Depression" may be helpful in supporting your therapy and reassuring the patient.

ANTIDEPRESSANT

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imipramine hydrochloride tablets, USP

10 mg, 25 mg, 50 mg

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rescribing Information:

ndications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than ther depressive states.

ontraindications: The concomitant use of monoamine xidase inhibiting compounds is contraindicated. Hyperyretic crises or severe convulsive seizures may occur in atients receiving such combinations. The potentiation of dverse effects can be serious or even fatal. When it is esired to substitute imipramine hydrochloride, in patients eceiving a monoamine oxidase inhibitor, as long an interval hould elapse as the clinical situation will allow, with a inimum of 14 days. Initial dosage should be low and ncreases should be gradual and cautiously prescribed.

The drug is contraindicated during the acute recovery eriod after a myocardial infarction. Patients with a known ypersensitivity to this compound should not be given the rug. The possibility of cross-sensitivity to other dibenazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine ydrochloride during pregnancy and lactation has not been stablished; therefore, this drug should be administered to omen who are or who might become pregnant, or to ursing mothers, only when the potential benefits clearly utweigh possible hazards. There have been clinical reports f congenital malformation associated with the use of this rug, but a causal relationship has not been confirmed. nimal reproduction studies with imipramine HCl have ielded inconclusive results. Oral studies in rats and mice at oses up to 2½ times, and in rabbits at doses up to 25 times he maximum human dose, showed no clear evidence of eratogenic potential, but subcutaneous studies showed a eratogenic effect in rabbits and equivocal teratogenicity in ice at respective doses up to 5 and 6½ times the maximum uman dose. Increased resorptions and stillbirths and deeased neonatal weights were seen in the oral as well as ubcutaneous studies.

xtreme caution should be used when this drug is given to:

patients with cardiovascular disease because of the possiility of conduction defects, arrhythmias, myocardial infarcion, strokes and tachycardia;

patients with increased intraocular pressure, history of rinary retention, or history of narrow-angle glaucoma beause of the drug's anticholinergic properties;

hyperthyroid patients or those on thyroid medication beause of the possibility of cardiovascular toxicity;

patients with a history of seizure disorder because this rug has been shown to lower the seizure threshold;

patients receiving guanethidine or similar agents since mipramine hydrochloride may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from linical trials in children, this drug is not recommended for se in patients under twelve years of age.

Since this drug may impair the mental and/or physical ibilities required for the performance of tasks such as operaion of an automobile or hazardous machinery, the patient hould be cautioned accordingly.

recautions: It should be kept in mind that the possibility of uicide in seriously depressed patients is inherent in the lness and may persist until significant remission occurs. uch patients should be carefully supervised during the early hase of treatment with imipramine hydrochloride and may equire hospitalization. Prescriptions should be written for he smallest amount feasible.

Hypomanic or manic episodes may occur, particularly n patients with cyclic disorders. Such reactions may necessiate discontinuation of the drug. If needed, imipramine hydochloride may be resumed in lower dosage when these pisodes are relieved. Administration of a tranquilizer may e useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride hould be discontinued for as long as the clinical situation will llow.

An activation of the psychosis may occasionally be bserved in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine hydrochloride with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine hydrochloride is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety,



Imavate®
imipramine hydrochloride
tablets, USP 10 mg, 25 mg, 50 mg

restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; cnstipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever or sore throat during therapy: the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast largement and galactorrhea in the female; increased o creased libido, impotence; testicular swelling; elevatio depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered function; weight gain or loss, perspiration; flushing; uri frequency; drowsiness, dizziness, weakness and fati headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of diction, abrupt cessation of treatment after prolon therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are rec mended for elderly patients and adolescents. Lower dosa are also recommended for outpatients as compared to h pitalized patients who will be under close supervision. age should be initiated at a low level and increased gra ally, noting carefully the clinical response and any evide of intolerance. Following remission, maintenance med tion may be required for a longer period of time, at the lo dose that will maintain remission.

Oral: *Usual Adult Dose: Hospitalized patients*—Initia 100 mg/day in divided doses gradually increased to 2 mg/day as required. If no response after two weeks, incre to 250-300 mg/day.

Outpatients—Initially, 75 mg/day increased to mg/day. Dosages over 200 mg/day are not recommend Maintenance, 50-150 mg/day.

Adolescent and geriatric patients—Initially, 30 mg/day; it is generally not necessary to exceed 100 mg/d

Overdosage: *Symptoms:* These include drowsin stupor, tachycardia, ataxia, vomiting, cyanosis, hypot sion, shock/coma, restlessness, agitation, hyperpyrexia, vere perspiration, hyperactive reflexes, muscle rigi athetoid movements, convulsions, mydriasis. There may cardiac arrhythmia, EKG evidence of impaired conduct and signs of congestive heart failure.

Treatment: There is no specific antidote. Indu emesis and gastric lavage are recommended. It may helpful to leave the tube in the stomach, with irrigation a continual aspiration of stomach contents, possibly prom ing more rapid elimination of the drug from the body. room should be darkened, allowing only a minimal amo of external stimulation, to reduce the tendency to con sions.

1. Hyperirritability and convulsions have been s cessfully treated with parenteral barbiturates in several stances. However barbiturates should not be employe drugs that inhibit monoamine oxidase have also been ta by the patient in overdosage or in recent therapy. Simila barbiturates may induce respiratory depression, particula in children. It is therefore advisable to have equipment av able for artificial ventilation and resuscitation when barb rates are employed. Paraldehyde has been used effectiv in some children to counteract muscular hypertonus a convulsions without causing respiratory depression. Anir data indicate that an internuncial neuron blocker, such methocarbamol, may be an effective treatment for con sions and muscular hypertonus.

2. Shock (circulatory collapse) should be treated w supportive measures such as intravenous fluids, oxyg and corticosteroids.

3. Hyperpyrexia should be controlled by whate means available, including ice packs, if necessary.

4. Signs of congestive heart failure have been satisf torily treated by rapid digitalization.

5. If an extremely large overdose has been ingest use of the artifical kidney may be helpful in eliminating drug from the body. However, due to low plasma levels the drug and a high rate of secretion in the stomach, it is that a more efficient technique is continuous gastric lavag

How Supplied: Imavate Tablets, brand of Imipram Hydrochloride Tablets, USP (film-coated), 10 mg (white) bottles of 100 (NDC 0031-5610); 25 mg (coral) in bott of 100 and 1000 (NDC 0031-5625); and 50 mg (fuchsia) bottles of 100 and 1000 (NDC 0031-5650). June 19

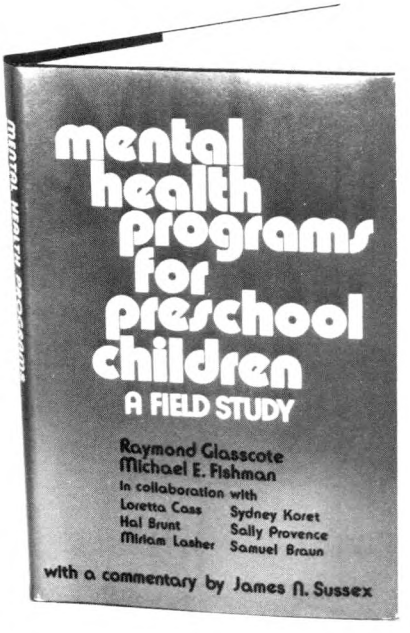
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A Timely New Book from The Joint Information Service

This latest Joint Information Service field study provides a concise, comprehensive overview of the complex matter of the very young American child and his mental health, and then describes in intimate detail seven unique programs for pre-school children with problems—from North Hollywood's Dubnoff Center, emphasizing education as its primary therapeutic modality, to Baltimore's Martin Luther King, Jr. Parent-Child Center, serving two housing projects, served by Johns Hopkins, and largely governed by its own people. All different in treatment approach and philosophy, the programs described are uniform in their dedication to innovation in improving service to the emotionally disturbed very young child, and, equally, to the emotional well being of all young children.

This thoughtful and perceptive description of what has been created by some of the best informed, most experienced and thoughtful specialists in mental health services for very young children should be welcome to all involved in the mental health of children and a casebook for those dealing with child and family mental health.



An articulate exposition of the immense problems and encouraging accomplishments in a particularly difficult area of endeavor . . . . Beyond their concern with the manifestly ill child, the authors intriguingly explore what may be needed to enhance the mental good health of all young children . . . . A significant contribution.

James N. Sussex, M.D.
President, American Association of Psychiatric Services for Children

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QUESTION:

WHAT TRICYCLIC ANTIDEPRESSANT IS AVAILABLE AS AN ORAL CONCENTRATE?

A

ANSWER:

SINEQUAN®

DOXEPIN HCl

ORAL CONCENTRATE

10 mg./ml., 120-ml. (4-oz.) bottles



- ☐ Effective in the treatment of clinical depression/anxiety
- ☐ Eliminates potential for "cheeking" medication
- ☐ Colorless, tasteless following dilution
- ☐ Contains no alcohol or sugar
- ☐ Easily mixed with water or juices

BRIEF SUMMARY

Sinequan® (doxepin HCl) **Capsules/Oral Concentrate**

Contraindications. Contraindicated in individuals who have shown hypersensitivity to the drug, and in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* This drug has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: Usage in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's). Sinequan (doxepin HCl) 25 mg. and 50 mg. also available in bottles of 5000. Sinequan Oral Concentrate (10 mg./ml.) is available in 120 ml. bottles with an accompanying dropper calibrated at 5 mg., 10 mg., 15 mg., 20 mg., and 25 mg.

More detailed professional information available on request.

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Adapting to age: time and the mind

Aging successfully: is the goal just survival?

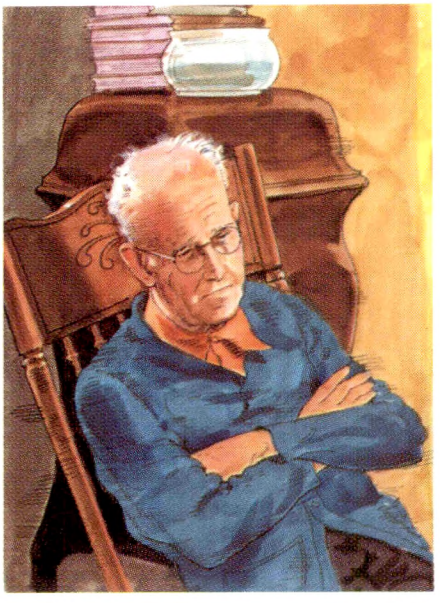
Popular belief would have it that "aging" and "existing" are the same, both marked by deteriorated ability—physical and mental. But is successful aging just existing?

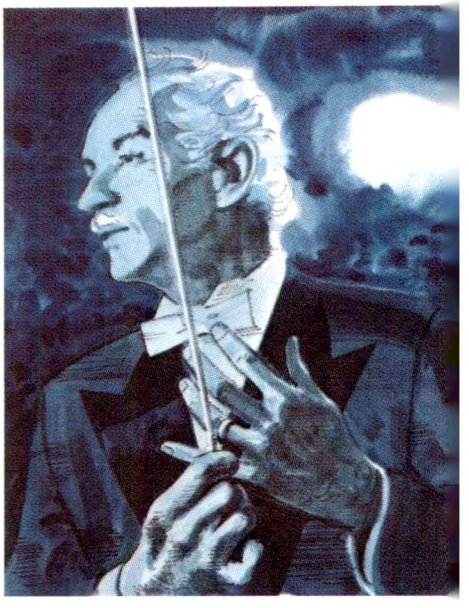
Or is it making the most of one's abilities?

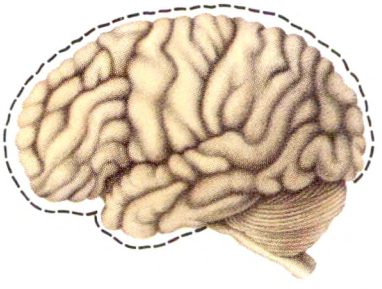
More than just surviving the changes and obstacles of old age, successful aging is *adapting* to the changes and *overcoming* the obstacles. Consider the very fortunate aging individuals who continue active, productive, even socially significant lives. Picasso, painting and sculpting until his death at the age of 91. Stokowski still conducting at 92. Margaret Mead, an active author and anthropologist at 73. Consider, too, those who lack prominence and popular acclaim, but still lead personally satisfying lives. Thus adding meaning to their prolonged existence by following interests and abilities.

How then, can some age so successfully, others less so, and still others merely survive? One reason: individual differences. Not only in abilities, but in opportunities and situations that can either nurture or suffocate ability.

Aging doesn't have to mean ailing bodies and failing minds. True, the cell loss of old age extends to the brain. But







the loss of brain cells doesn't invariably lead to loss of intelligence and alertness. For,

Although the decrease in brain volume is well known, enormous reserves of cerebral cells help compensate for loss with age. Disease and injury, more than advancing age, actually lessen cerebral capacity.

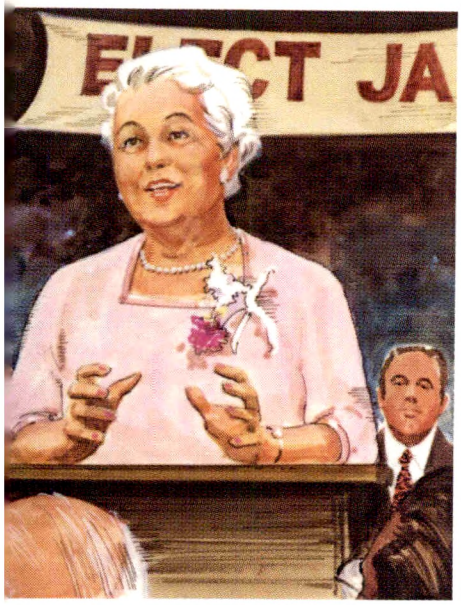
And lack of use contributes to the decline; mental and physical functions that are utilized tend to persist and those not utilized tend to disappear. So, if used, the mind often can remain alert. And, in fact,

Some now believe that intellectual decline can be minimal.

One theory isolates two basic types of intelligence: "fluid" and "crystallized." Both increase into adolescence, but fluid intelligence, formless and independent of education, begins to decline during the twenties. Crystallized intelligence—experience refined through education—continues to grow, and does not decline or even level off during old age. So, according to this theory, total intelligence changes qualitatively. Quantitatively, it remains relatively constant.

But we still see senility and seeming mental decline, sometimes caused by





injury to the brain from accident or a disease like cerebral arteriosclerosis. In some cases, the reason may be personality frustration even more than actual brain deterioration: a decline in *performance* generated by severe stress more than a decline in *cognitive ability.* Clinically significant anxiety, alone or associated with underlying organic disease, is common in the elderly, and can cripple the aged mind, and interfere with the adaptive process. But

When such anxiety is controlled the elderly patient may become more responsive to personal interests and social activities. To therapy and counselling. To adapting to the changes of age.

If antianxiety therapy adjunctive to your counsel and reassurance is desirable, consider Serax (oxazepam). Serax has been found valuable, particularly in the older patient, in the management and control of clinically significant anxiety, tension, agitation and irritability.

Special care must of course be taken in prescribing antianxiety agents for elderly patients, especially where cardiac complications might ensue from a drop in blood pressure. And careful attention must be paid to dosage recommendations and follow-up observation.

More than eight years of clinical experience have shown Serax to be especially useful in many geriatric patients. Its dosage flexibility* generally permits adjustment to individual patient needs, making Serax a logical choice in the management of clinically significant anxiety in the elderly patient.

In Brief:

Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease. Anxiety associated with depression is also responsive to oxazepam therapy. This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients. Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

*See package circular for full prescribing information.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: Use in Pregnancy: Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Not indicated in children under 6 years; absolute dosage for 6- to 12-year olds not established.

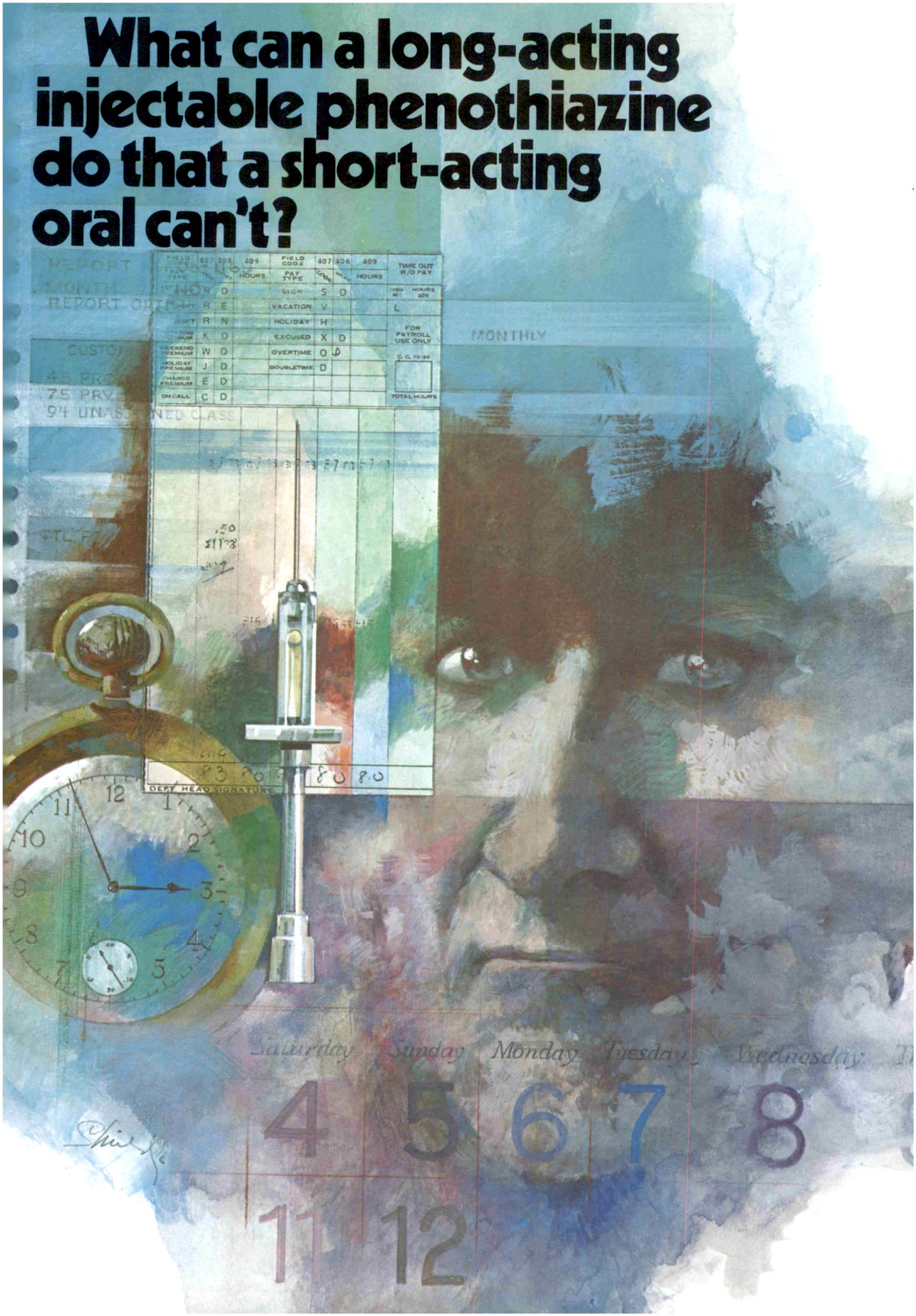
Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Wyeth Laboratories · Philadelphia, Pa. 19101

Wyeth
makers of Serax® (oxazepam)
for use in clinically significant anxiety

What can a long-acting injectable phenothiazine do that a short-acting oral can't?



It can save time, it can save money, and it can even save people – by reducing readmissions.

Time Prolixin Decanoate (Fluphenazine Decanoate Injection), with duration of action that may last up to 4 weeks or longer in patients on maintenance therapy, can effect important savings in nursing time.

Approximate Staff Time Required to Medicate 18 Schizophrenic Patients*

8 a.m. ¾ hr. 1 p.m. ¾ hr. 5 p.m. ¾ hr.	1 injection every 28 days for most patients
= 2¼ hours nursing time	4 minutes required for each injection
2¼ hrs. x 28 days = 63 hours of nursing time every 28 days	= 1 hr., 10 minutes nursing time in 28 days
NURSING TIME SAVED IN 28 DAYS	61 hours and 50 minutes or more than 7½ eight-hour working days

*Adapted from Platt R: Br J Social Psychiatry 2: 187-191, 1968.

Money Martin and Townend[1], who found from their study of Prolixin Decanoate that 15 of 39 patients could be maintained on 25 mg. every 4 weeks, also note that on this basis "a year's maintenance on chlorpromazine represents the order of 110 grams of phenothiazine as opposed to 0.33 gram of fluphenazine." Translating this into dollars shows the following potential hospital savings on the basis of patient population:

Agent and amount/year	Form	Cost/patient/year	Cost/500 patients/year
Chlorpromazine (SKF brand) 110 grams	8 oz. concentrate 100 mg./ml.†	$48.75*	$24,375
Prolixin Decanoate .33 grams	5 ml. vials 25 mg./ml.	23.17**	11,585
SAVINGS		$25.58 patient, year	$12,790 500 pts/yr.

* Calculated from prices published in 1975 Red Book.
** Calculated from Squibb 1975 price catalogue.
† With tablets, the annual cost is even greater.

People The controlled drug delivery system of Prolixin Decanoate helps get schizophrenic patients out of the hospital and helps them stay out. It promotes continuity of therapy—reducing outpatient drug defaulting from approximately 50% with oral medications according to one report[2] to about 16% according to another report[3].

It reduces the number and length of rehospitalizations. In one study of 103 patients maintained on injections of long-acting fluphenazines, total hospital readmissions for a year were cut from 191 to 50 and inpatient time from 8,713 days to 1,335 days[4].

It facilitates return to a productive life. A 12-month followup of 103 discharged patients revealed 77% in full-time employment or household duties and only 23% unemployed[4].

PROLIXIN DECANOATE®

(Fluphenazine Decanoate Injection)

may control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

SQUIBB® 'The Priceless Ingredient of every product is the honor and integrity of its maker.'™

References:
1. Martin ICA and Townend RA: Brit J Psychiat 124: 173-6, 1974.
2. Goldberg HL, DiMascio A, Chaudhary B: Psychosomatics 11: 173-177, 1970.
3. Medical World News, February 11, 1972, p. 58H.
4. Denham J and Adamson L: Can Psychiat Assoc J 18: 235-7, 1973.

For product brief summary see following page.

H425-001R

PROLIXIN DECANOATE®

(Fluphenazine Decanoate Injection)

...ay control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

olixin Decanoate (Fluphenazine Decanoate Injection) provides
mg. fluphenazine decanoate per ml. In a sesame oil vehicle with
% (w/v) benzyl alcohol as a preservative.

NTRAINDICATIONS: In presence of suspected or established sub-
tical brain damage. In patients who have a blood dyscrasia, liver
nage or renal insufficiency, or who are receiving large doses of
onotics, or who are comatose or severely depressed. In patients who
ve shown hypersensitivity to fluphenazine; cross-sensitivity to phe-
hiazine derivatives may occur.
Not intended for use in children under 12.

ARNINGS: Mental and physical abilities required for driving a car
operating heavy machinery may be impaired by use of this drug.
ysicians should be alert to the possibility that severe adverse re-
ions may occur which require immediate medical attention. Potentia-
n of effects of alcohol may occur. Safety and efficacy in children
ve not been established because of inadequate experience in use
children.

sage in Pregnancy: Safety for use during pregnancy has not been
ablished; weigh possible hazards against potential benefits if ad-
nistering this drug to pregnant patients.

ECAUTIONS: Caution must be exercised if another phenothiazine
mpound caused cholestatic jaundice, dermatoses or other allergic
actions because of the possibility of cross-sensitivity. When psychotic
ients on large doses of a phenothiazine drug are to undergo surgery,
otensive phenomena should be watched for; less anesthetics or
tral nervous system depressants may be required. Because of added
cholinergic effects, fluphenazine may potentiate the effects of
opine.
Use fluphenazine decanoate cautiously in patients exposed to ex-
me heat or phosphorus insecticides; in patients with a history of
nvulsive disorders since grand mal convulsions have occurred; and
patients with special medical disorders such as mitral insufficiency
other cardiovascular diseases, and pheochromocytoma. Bear in
nd that with prolonged therapy there is the possibility of liver damage,
mentary retinopathy, lenticular and corneal deposits, and develop-
nt of irreversible dyskinesia.
Fluphenazine decanoate should be administered under the direction
a physician experienced in the clinical use of psychotropic drugs.
riodic checking of hepatic and renal functions and blood picture
ould be done. Renal function of patients on long-term therapy should
monitored; if BUN becomes abnormal, treatment should be dis-
ntinued. "Silent pneumonias" are possible.

VERSE REACTIONS: *Central Nervous System*—Extrapyramidal
mptoms are most frequently reported. These include pseudoparkin-
ism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos,
d hyperreflexia; most often these are reversible, but they may be
rsistent. One can expect a higher incidence of such reactions with
phenazine decanoate than with less potent piperazine derivatives
straight-chain phenothiazines. The incidence and severity will de-
nd more on individual patient sensitivity, but dosage level and patient
e are also determinants. As these reactions may be alarming, the
tient should be forewarned and reassured. These reactions can usually
controlled by administration of antiparkinsonian drugs such as benz-
pine mesylate or intravenous Caffeine and Sodium Benzoate Injec-
n U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, per-
tent and sometimes irreversible tardive dyskinesia may appear in
me patients on long-term therapy or may occur after discontinuation
drug. The risk seems greater in elderly patients, especially females.
high dosages. The syndrome is characterized by rhythmical involun-
y movements of tongue, face, mouth, or jaw (e.g., protrusion of
ngue, puffing of cheeks, puckering of mouth, chewing movements)
d may be accompanied by involuntary movements of extremities.
ere is no known effective therapy for tardive dyskinesia; usually the
mptoms are not alleviated by antiparkinsonism agents. If the symptoms
pear, discontinuation of all antipsychotic agents is suggested. The
ndrome may be masked if treatment is reinstituted, or drug dosage
creased, or a different antipsychotic agent used. Reports are that
e vermicular movements of the tongue may be an early sign of the
ndrome which may not develop if medication is stopped at that time.
Phenothiazine derivatives have been known to cause restlessness,
citement, or bizarre dreams; reactivation or aggravation of psychotic
ocesses may be encountered. If drowsiness or lethargy occur, the
sage may have to be reduced. Dosages, far in excess of the recom-
nded amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood
essure have been reported. Although hypotension is rarely a prob-
n, patients with pheochromocytoma, cerebral vascular or renal in-
fficiency or severe cardiac reserve deficiency such as mitral insuf-
ficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 ml. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 ml. vials.

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Make psychiatric history!

Up here in Maine, we're making some of the most exciting innovations in America.

We're the Augusta Mental Health Institute, Northern New England's outstanding JCAH – accredited hospital. Right now, we need a special breed of Board Eligible or Certified Psychiatrists to join us and help us make history. AMHI is a unitized, participatory management institution that's already a national model for providing services to a rural society.

We've done a lot already and we're not finished yet. We want only flexible, creative types interested in making great professional strides in treatment.

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Augusta Mental Health Institute

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Augusta Mental Health Institute
Augusta, Maine 04330. Phone: 207-622-3751

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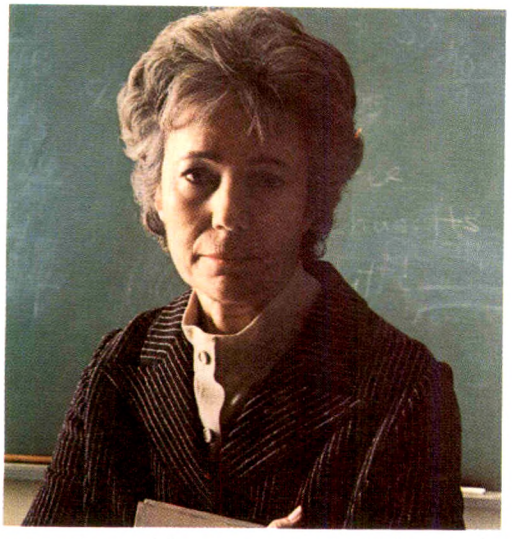
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Medical Manpower Committee,
Prince George Regional Hospital,
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FACULTY POSITION IN PSYCHIATRY AVAILABLE

Texas A&M University is currently developing a new Program in Medical Education; the two-year preclinical course of instruction will be presented primarily on the TAMU campus; the clinical curriculum, occupying the 3rd and 4th years, will utilize the faculty and facilities of the Baylor College of Medicine and its affiliated hospitals in Houston as well as the Veterans Administration Center and the Scott & White Clinic and Hospital in Temple, Texas. A program director for psychiatry and behavioral science is needed. Teaching in the first two years of medical school will be a major responsibility. Qualified persons are invited to make application. Letters of application should include a resume of pertinent prior experience and training and may be directed to James A. Knight, M.D., Dean of Medicine, Texas A&M University, College Station, Texas 77843.

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In the treatment of middle-age depression, there may be one thing to add...



Although the causes of depression in middle-aged women are varied, estrogen depletion is believed by many to be a significant contributing factor in depressions arising in the menopausal years.[1-7]

In the absence of a history of overt psychosis, estrogen replacement therapy alone, or in conjunction with antidepressants and counseling, may provide physiological and, in turn, psychological effect to enhance the total therapy.[7] Estrogen replacement has been noted to relieve the symptoms of estrogen-related depression in a relatively short time.[8] When used with antidepressants, estrogens may help bring about a generalized emotional improvement in patients, while waiting for initial response to slower acting antidepressants.

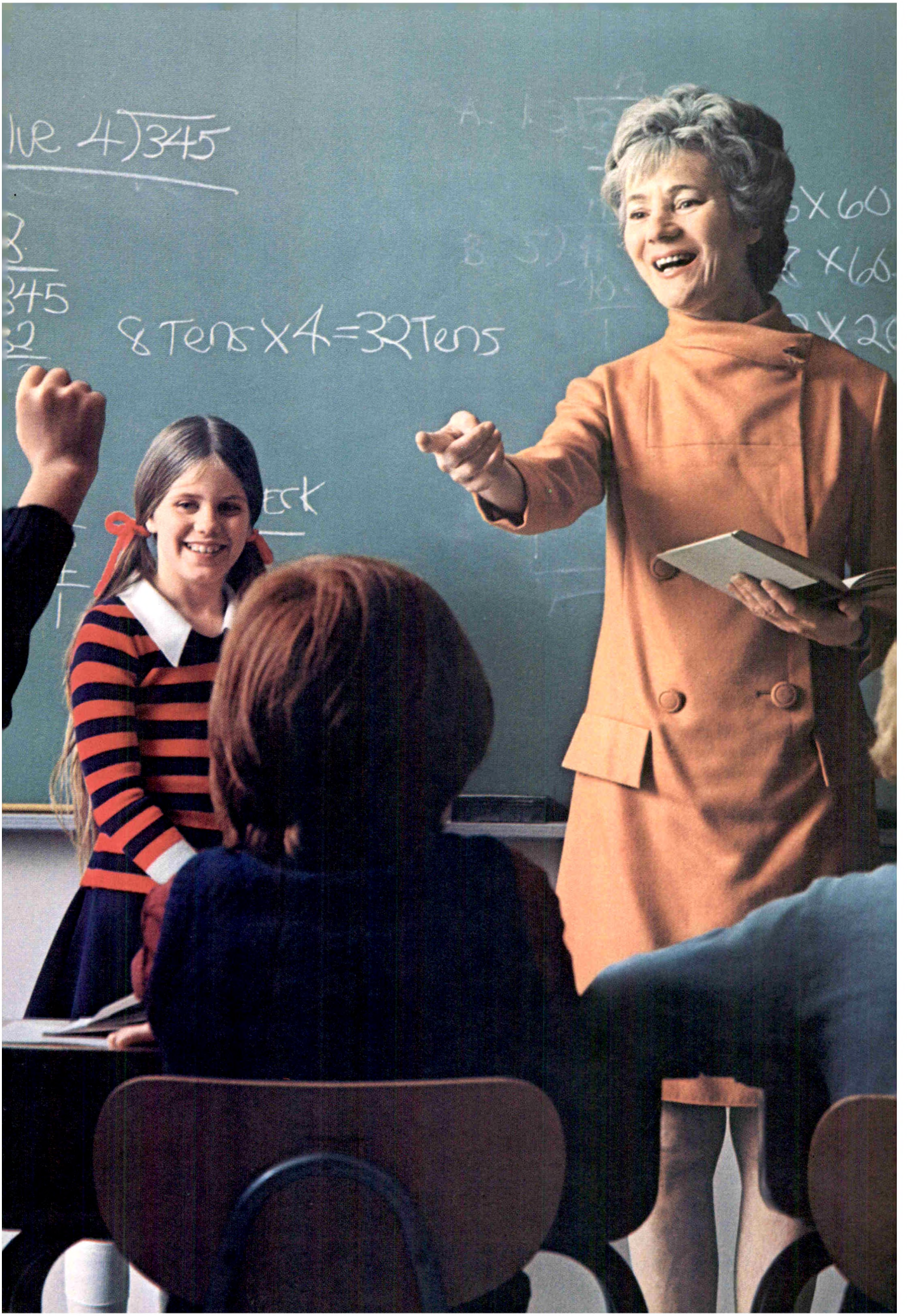
In many estrogen deficient patients, PREMARIN® (Conjugated Estrogens Tablets, U.S.P.) imparts a renewed sense of well-being. It helps alleviate depressive symptoms related to menopausal estrogen deficiency, while helping to identify those that aren't.

Crying spells, insomnia, fatigue, headache, feelings of weakness and other such symptoms may be relieved by estrogen replacement.[6,7] At the same time, the classic autonomic and metabolic symptoms of the climacteric may be controlled.[9,10]

PREMARIN® CONTAINS NATURAL ESTROGENS EXCLUSIVELY
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

for estrogen-related depression

See last page of advertisement for prescribing information.


8 Tens x 4 = 32 Tens

PREMARIN®

BRAND OF

CONJUGATED ESTROGENS TABLETS, U.S.P.

for estrogen-related depression

contains natural estrogens exclusively



BRIEF SUMMARY (For full prescribing information, see package circular.)

PREMARIN® (CONJUGATED ESTROGENS TABLETS, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences – National Research Council and/or other information, FDA has classified the indications for use as follows.

Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.

"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period – withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens, therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration.

- nausea, vomiting, anorexia
- gastrointestinal symptoms such as abdominal cramps and bloating
- breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
- breast tenderness and enlargement
- reactivation of endometriosis
- possible diminution of lactation when given immediately postpartum
- loss of libido and gynecomastia in males
- edema
- aggravation of migraine headaches
- change in body weight (increase, decrease)
- headache
- allergic rash
- hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome – 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause – as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae) – 0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression) – usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus – 0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865 – Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000. No. 866 – Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 867 – Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. No. 868 – Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

References: 1. Kaufman, S.A.: Obstet. Gynecol. *30*:399 (Sept.) 1967. 2. McEwen, D.C.: Can. Nurse *63*:34 (Feb.) 1967. 3. Kaufman, S.A., in Olds, S.: Today's Health *48*:48 (May) 1970. 4. Klaiber, E.L., *et al.*: Am. J. Psychiatry *128*:1492 (June) 1972. 5. Rhoades, F.P.: Mich. Med. *64*:410 (June) 1965. 6. Rhoades, F.P.: J. Am. Geriatr. Soc. *15*:346 (Apr.) 1967. 7. Kerr, M.D.: Mod. Treat. *5*:587 (May) 1968. 8. Tramont, C.B.: Geriatrics *21*:212 (Nov.) 1966. 9. Kupperman, H.S.: Med. Aspects Hum. Sexuality *1*:64 (Sept.) 1967. 10. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, chap. 69, p. 1538 ff.

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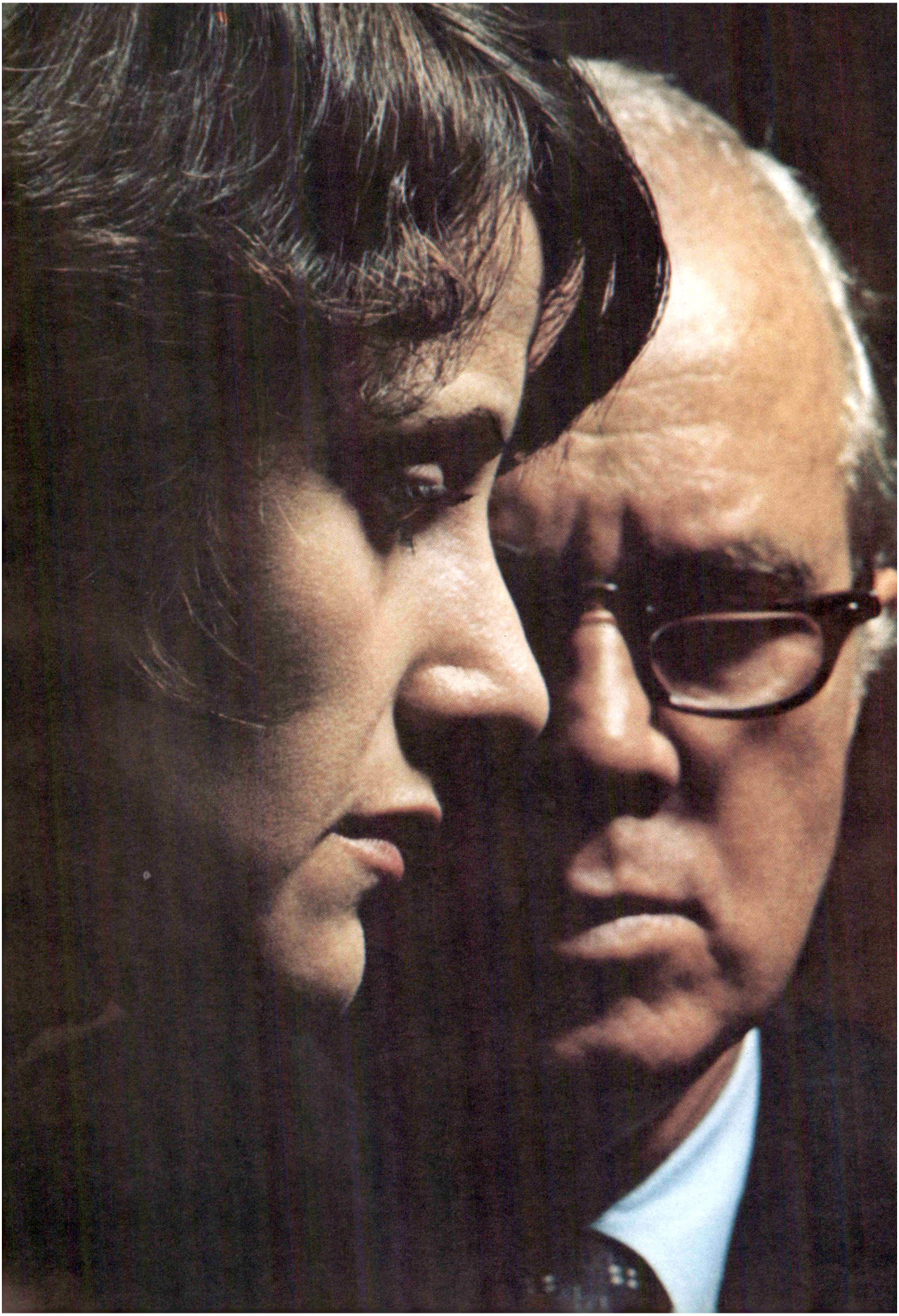
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For a brief summary of prescribing information, please turn to the following page.

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WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastic distress; vomiting; anorexia stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information.
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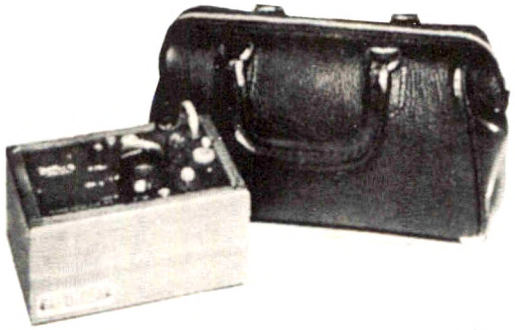
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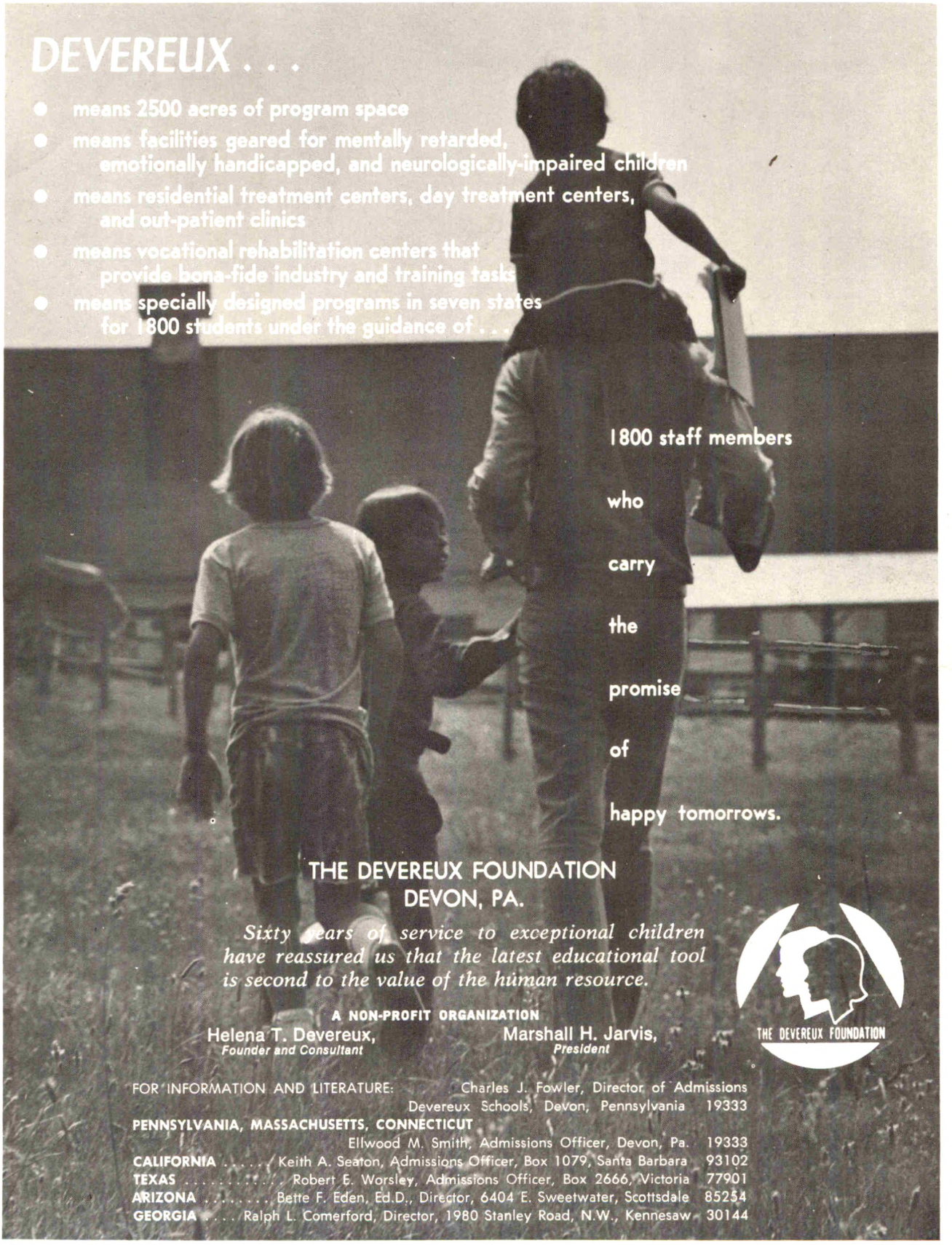
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THE AMERICAN JOURNAL OF PSYCHIATRY

In this issue

Frank J. Ayd, Jr., on
The Depot Fluphenazines

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Indications
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, pancytopenia, anemia, cholestatic jaundice, liver damage have been reported.

Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema, reversed epinephrine effect; hyperpyrexia; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

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Volume 2: Childhood and Adolescence
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Summer 1975 500 pp. illus. $38.00

Abnormalities in Parents of Schizophrenics

S. R. Hirsch, Westminster Medical School, University of London, and **J. P. Leff,** Institute of Psychiatry, London. ☐ Up to the present a comprehensive review of the role of parents in the etiology of schizophrenia has not been attempted. Although several previous reviews have covered different aspects of the subject, research has been proceeding within a number of different disciplines using a variety of approaches—questionnaire studies, small group interaction studies, psychological tests for abnormal thought processes, and abnormalities of communication and language. This study reviews these approaches.
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Famine and Human Development

The Dutch Hunger Winter of 1944-45
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1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

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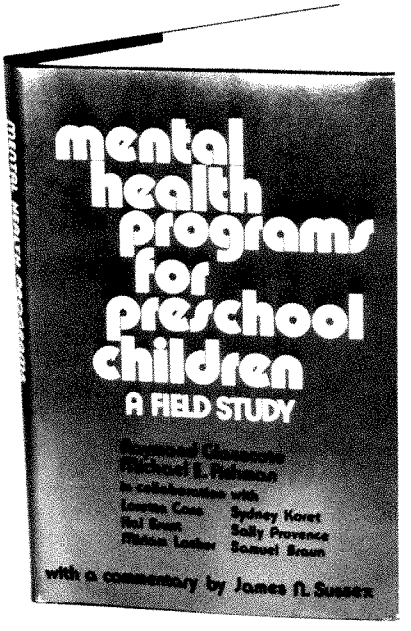
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Indications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious, or even fatal. When it is desired to substitute Tofranil, brand of imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine during pregnancy and lactation has not been established; therefore, in administering the drug to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed.

Extreme caution should be used when this drug is given to:

- —patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- —patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- —hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- —patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- —patients receiving guanethidine or similar agents since imipramine may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, Tofranil, brand of imipramine hydrochloride, is not recommended for treatment of depression in patients under twelve years of age.

Tofranil-PM, brand of imipramine pamoate, should not be used in children of any age because of the increased potential for acute overdosage due to the high unit potency (75 mg., 100 mg., 125 mg. and 150 mg.). Each capsule contains imipramine pamoate equivalent to 75 mg., 100 mg., 125 mg. or 150 mg. imipramine hydrochloride.

Since imipramine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with Tofranil, brand of imipramine hydrochloride, and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil, brand of imipramine hydrochloride, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations; disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. Dosage should be initiated with Tofranil, brand of imipramine hydrochloride, at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission.

Once-a-day maintenance dosage can be provided with Tofranil-PM, brand of imipramine pamoate, capsules if this dosage has been established as explained above. This dose may be given at bedtime. For the occasional patient who manifests stimulation and insomnia with this dosage regimen, the capsules may be given in the morning.

Parenteral administration should be used only for starting therapy in patients unable or unwilling to use oral medication. The oral form should supplant the injectable as soon as possible.

How Supplied: Tofranil, brand of imipramine hydrochloride: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg.; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-850-P (2/74)

For complete details, including dosage and administration, please refer to the full prescribing information.

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For a brief summary of prescribing information, please turn to the following page.

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WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); alterec cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension, hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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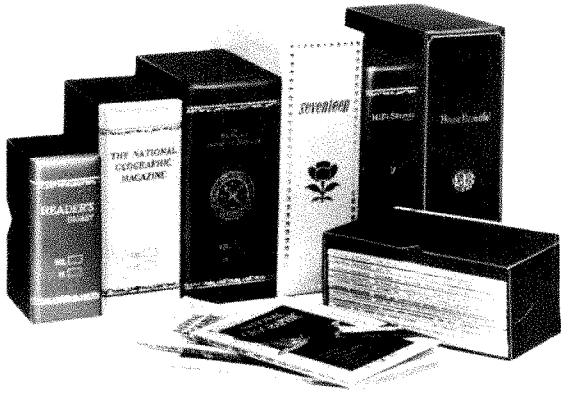
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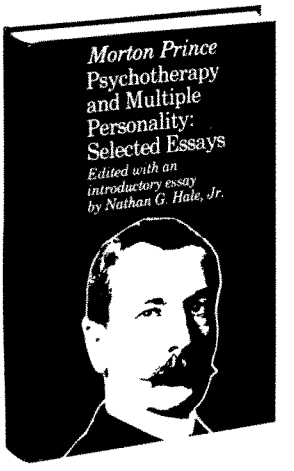


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Adapting to age: time and the mind

Aging successfully: is the goal just survival?

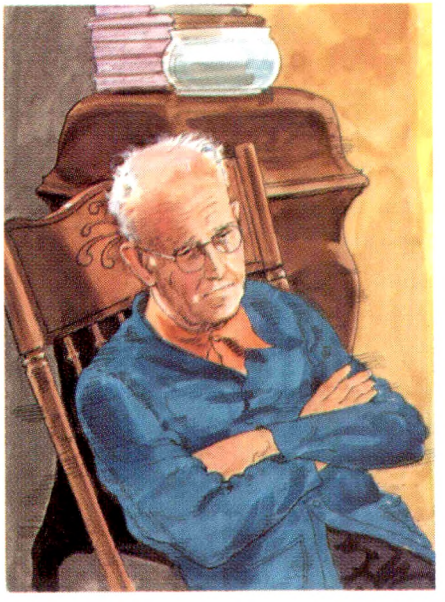
Popular belief would have it that "aging" and "existing" are the same, both marked by deteriorated ability—physical and mental. But is successful aging just existing?

Or is it making the most of one's abilities?

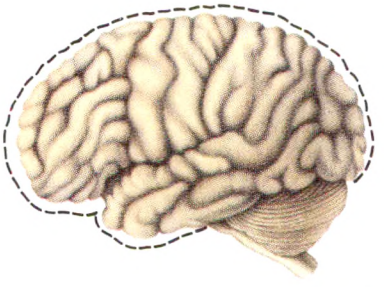
More than just surviving the changes and obstacles of old age, successful aging is *adapting* to the changes and *overcoming* the obstacles. Consider the very fortunate aging individuals who continue active, productive, even socially significant lives. Picasso, painting and sculpting until his death at the age of 91. Stokowski still conducting at 92. Margaret Mead, an active author and anthropologist at 73. Consider, too, those who lack prominence and popular acclaim, but still lead personally satisfying lives. Thus adding meaning to their prolonged existence by following interests and abilities.

How then, can some age so successfully, others less so, and still others merely survive? One reason: individual differences. Not only in abilities, but in opportunities and situations that can either nurture or suffocate ability.

Aging doesn't have to mean ailing bodies and failing minds. True, the cell loss of old age extends to the brain. But







the loss of brain cells doesn't invariably lead to loss of intelligence and alertness. For,

Although the decrease in brain volume is well known, enormous reserves of cerebral cells help compensate for loss with age. Disease and injury, more than advancing age, actually lessen cerebral capacity.

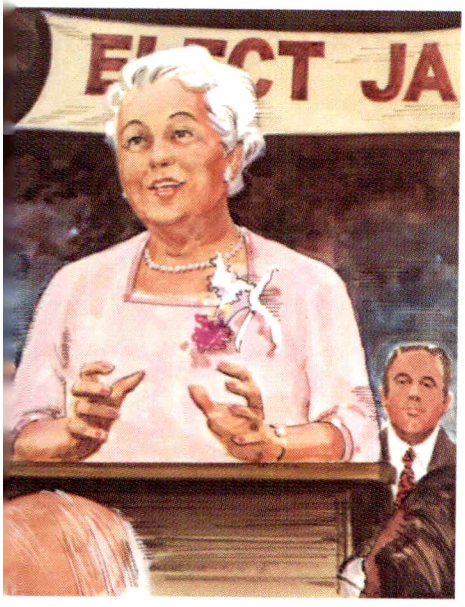
And lack of use contributes to the decline; mental and physical functions that are utilized tend to persist and those not utilized tend to disappear. So, if used, the mind often can remain alert. And, in fact,

Some now believe that intellectual decline can be minimal.

One theory isolates two basic types of intelligence: "fluid" and "crystallized." Both increase into adolescence, but fluid intelligence, formless and independent of education, begins to decline during the twenties. Crystallized intelligence—experience refined through education—continues to grow, and does not decline or even level off during old age. So, according to this theory, total intelligence changes qualitatively. Quantitatively, it remains relatively constant.

But we still see senility and seeming mental decline, sometimes caused by





injury to the brain from accident or a disease like cerebral arteriosclerosis. In some cases, the reason may be personality frustration even more than actual brain deterioration: a decline in *performance* generated by severe stress more than a decline in *cognitive ability.* Clinically significant anxiety, alone or associated with underlying organic disease, is common in the elderly, and can cripple the aged mind, and interfere with the adaptive process. But

When such anxiety is controlled the elderly patient may become more responsive to personal interests and social activities. To therapy and counselling. To adapting to the changes of age.

If antianxiety therapy adjunctive to your counsel and reassurance is desirable, consider Serax (oxazepam). Serax has been found valuable, particularly in the older patient, in the management and control of clinically significant anxiety, tension, agitation and irritability.

Special care must of course be taken in prescribing antianxiety agents for elderly patients, especially where cardiac complications might ensue from a drop in blood pressure. And careful attention must be paid to dosage recommendations and follow-up observation.

More than eight years of clinical experience have shown Serax to be especially useful in many geriatric patients. Its dosage flexibility* generally permits adjustment to individual patient needs, making Serax a logical choice in the management of clinically significant anxiety in the elderly patient.

In Brief:

Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease. Anxiety associated with depression is also responsive to oxazepam therapy. This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients. Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

*See package circular for full prescribing information.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: Use in Pregnancy: Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Not indicated in children under 6 years; absolute dosage for 6- to 12-year olds not established.

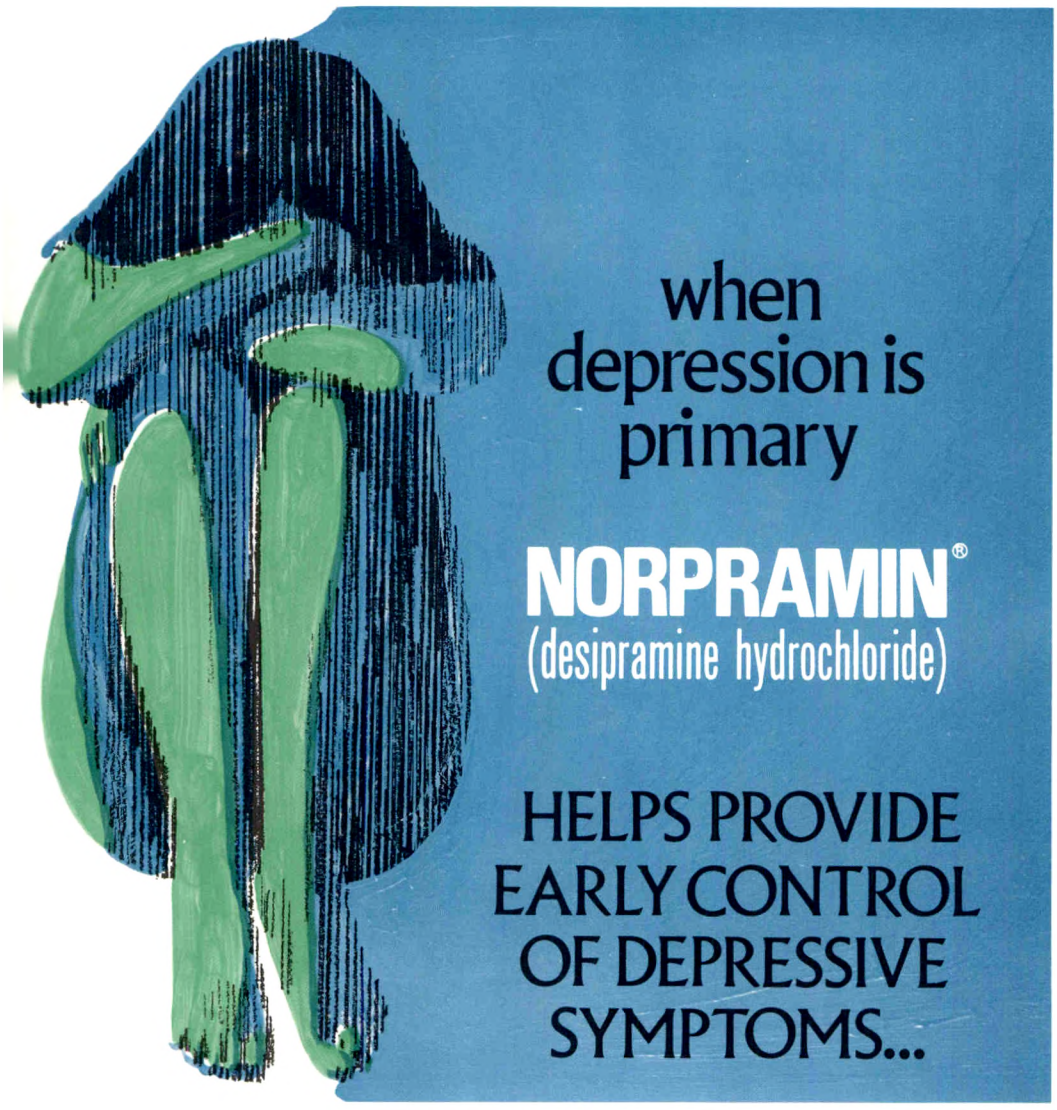
Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

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Wyeth
makers of Serax® (oxazepam)
for use in clinically significant anxiety


When you see anxiety–look for depression
NORPRAMIN®
(desipramine hydrochloride)



when depression is primary

NORPRAMIN®
(desipramine hydrochloride)

HELPS PROVIDE EARLY CONTROL OF DEPRESSIVE SYMPTOMS...

Anxiety is an invidious symptom. It feeds upon sickness, gnaws, grows and invades every cranny of psychic pathology adding intensity to torment. Anxiety as a symptom secondary to depression may be so dominant that it obscures the primary diagnosis. It may suggest treatment with tranquilizers which often help. But as the vampire of legend had to have a laurel stake driven through its heart to truly die, so anxiety secondary to depression will not cease to nibble and bite until an antidepressant eradicates the primary illness—and symptomatic anxiety starves

Norpramin® (desipramine hydrochloride) 25 mg. and 50 mg. tablets.

IN BRIEF:

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. If possible, dispense in child-resistant containers. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of phychosis in schizophrenic patients. Use cautiously with anticholinergic or sympathomimetic drugs. Response to alcoholic beverages may be exaggerated. In the concurrent administration of ECT and antidepressant drugs one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of phychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

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Almost any tranquilizer might calm her down...

but at her age, estrogen may be what she really needs.



Throughout a woman's life, periods of low endogenous estrogen production often coincide with heightened levels of anxiety and tension.

In the menopause, many of these symptoms—tension, irritability, headaches, undue fatigue, depression, and insomnia—may respond, at least initially, to minor tranquilizers and antidepressants.

But these symptoms, when caused by declining menopausal estrogen levels, may also be relieved with PREMARIN, which treats the underlying cause by providing adequate estrogen replacement.

And that's something tranquilizers can't do.

In many cases, prolonged use of tranquilizers will not be necessary; patients taking PREMARIN alone often report relief of emotional symptoms due to estrogen deficiency...and an improved sense of well-being.

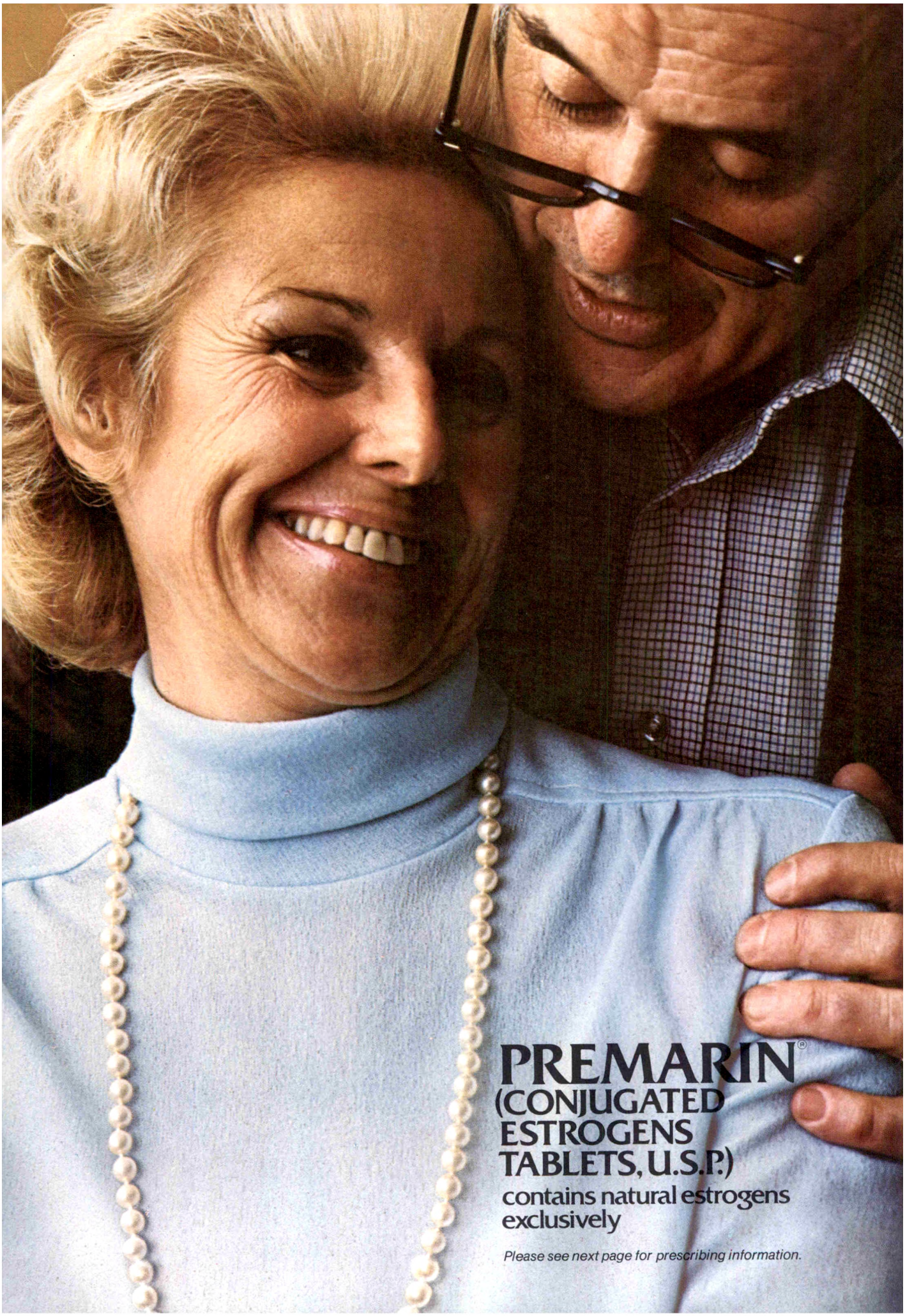
At the same time, PREMARIN helps relieve concomitant vasomotor symptoms, such as hot flushes and sweats...reverse genital tissue atrophy ...retard postmenopausal osteoporotic changes.*

A simple therapeutic trial is often all that's needed to distinguish between estrogen-related and purely psychogenic symptoms.

PREMARIN.

For what's really missing in the menopause.

*Conjugated Estrogens Tablets have been evaluated as "probably effective" for postmenopausal osteoporosis.


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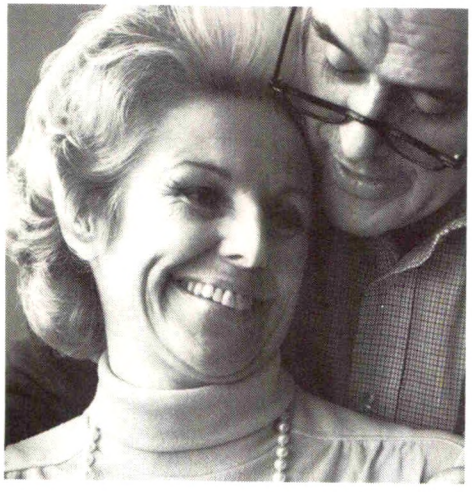
even when you start with a tranquilizer, replace estrogen

PREMARIN®

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contains natural estrogens exclusively



BRIEF SUMMARY *(For full prescribing information, see package circular.)*

PREMARIN® (CONJUGATED ESTROGENS TABLETS, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000. No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

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The second edition of this popular, practical guide is expanded to include more data on examining pre-school children. Stressed is importance of assessing developmental levels and rates, inclusion of parents in on-going diagnosis, and remedial procedures to enhance optimal development and provide accurate prognosis. "This handbook should be a part of the minimum library of every student and teacher of psychiatry." — *American Journal of Psychiatry.*

By JAMES E. SIMMONS, M.D., Indiana University School of Medicine, Indianapolis. *239 pp. (5¼ x 7¾), paperback, 1974, $6.00.*

Clinical Aspects of Child Development: An Introductory Synthesis of Psychological Concepts and Clinical Problems. By MELVIN LEWIS, M.D., Yale University, New Haven, Connecticut. *212 pp. (5¼ x 7¾), illus., paperback, 1971, $4.75.*

Problems in Child Behavior and Development. By MILTON J. E. SENN, M.D., and ALBERT J. SOLNIT, M.D., both of the Yale University School of Medicine, New Haven, Connecticut. *268 pp., 1968, $8.50.*

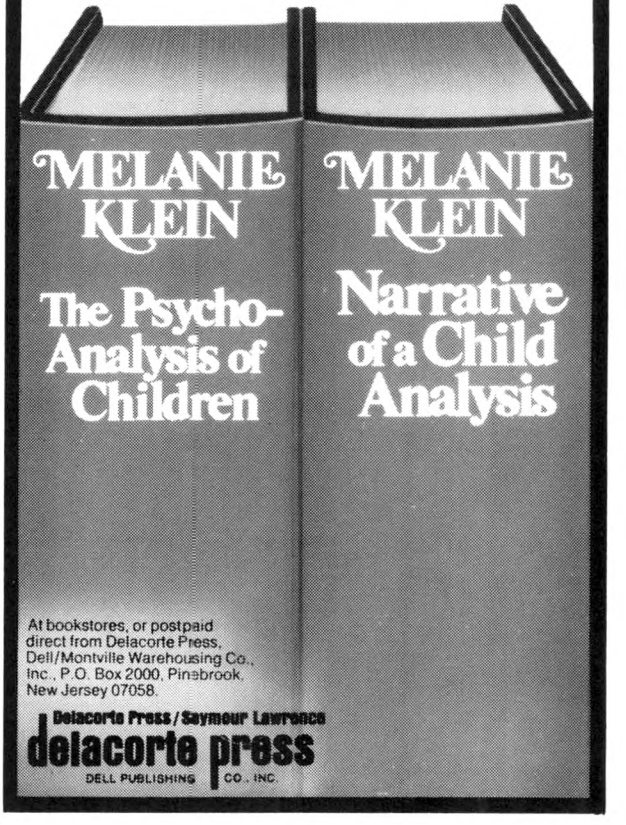
Textbook of Child Neurology. By JOHN H. MENKES, M.D., University of California at Los Angeles. In consultation and with a contribution by MARCEL KINSBOURNE, M.D., Ph.D. (3 Contributors). *583 pp. (7 x 10), 130 illus., 1974, $22.50.*

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"An extremely valuable contribution to psychological historical scholarship."—George E. Gardner, Ph.D., M.D., *Harvard Medical School*

Just reissued, these newly revised translations make available two standard works in the field of child psycho-analysis. THE PSYCHO-ANALYSIS OF CHILDREN describes both the Kleinian theory and methods, and is generally recognized as a classic work which revolutionized child analysis ($17.50). NARRATIVE OF A CHILD ANALYSIS is a fascinating case study of a ten-year-old boy, including the reproduction and analysis of 74 drawings made by the patient ($20.00).

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in clinically significant depression...

penetrating the symptom barrier to productive psychotherapy

symptoms often interfere with therapy

In clinically significant depression, the patient often becomes barricaded behind his own symptoms during psychotherapy. Because these symptoms can be so sharply defined and somatic in expression, he may reject the fact that they are psychic in origin. Sleep disturbance, gastrointestinal complaints, anorexia, chronic fatigue, and other psychosomatic symptoms may so preoccupy—or overwhelm—the depressed patient that truly productive therapeutic sessions are difficult to achieve. Instead of being able to concentrate on the core emotional problems of the depression itself, he may for example go on at length about how broken his sleep is or keep reiterating (while the therapeutic hour slips by) how physically miserable he feels.

ELAVIL®
(AMITRIPTYLINE HCl, MSD)
to help penetrate the symptom barrier in depression requiring medication

ELAVIL, a highly effective tricyclic antidepressant, will often alleviate these symptoms. With the help of ELAVIL, sleep disturbance—so common in clinically depressed patients and often the symptom that distresses them most—as



well as other "barrier symptoms" may be lessened to the point where they no longer come between you and the patient.

psychotherapy takes direction

As these preoccupying complaints are lifted, psychotherapy sessions can become more productive. Patients are enabled to respond more fruitfully during therapeutic hours and to resume or pursue more efficiently the necessary activities in their personal lives.

meeting therapeutic goals

And as the antidepressant activity of ELAVIL (Amitriptyline HCl, MSD) takes hold, it helps relieve the depressive condition itself. Sometimes only a minimum of actual psychotherapy is required. The patient may experience a more rapid recovery—while you conserve valuable time.

Prescribe ELAVIL then, to help lighten the patient's burden in depression—and yours in its management.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps increase your effectiveness in managing clinically significant depression



MSD
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For a brief summary of prescribing information, please see following page.

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addendum

In adult outpatients
with clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

once a day AT BEDTIME or **divided dosage** DAILY

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.
When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

ELAVIL
(AMITRIPTYLINE HCl, MSD)

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He has disrupted his family...
his teacher's classroom...
and his own life.
But he can't help it. He has MBD.

A symptom profile of the hyperkinetic child

Marked hyperactivity; most pronounced in home or school; in more severe cases, the child seems "driven", is constantly in motion, in a random, purposeless way.

Short attention span; concentration fragmented or easily fatigued, particularly in static activities such as reading or schoolwork.

Distractibility; easily diverted from the task at hand; leaves work unfinished; becomes impatient easily.

Emotional lability; wide swings of mood, with frequent temper tantrums; often destructive, yet "can't help himself"; frequently creates serious problems in classrooms.

Impulsivity; acts or speaks abruptly without consideration of the consequences.

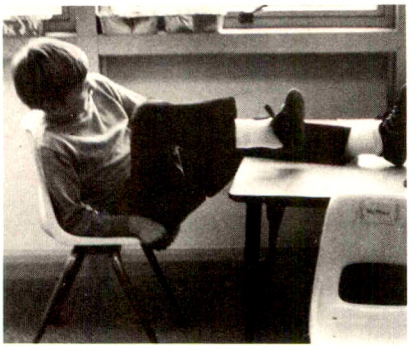
Impaired coordination; often shows in simpler motor tasks requiring concentration (i.e. drawings lack cohesion, handwriting is poorly organized.)

Learning disability; a frequent underachiever, though I.Q. may be normal or above; problems often relate to perceptual difficulties—poor differentiation of words and letters, confused directionality.

As a result of his disabilities, the MBD child is tormented by daily frustrations and feelings of failure. "Aware that their controls are inadequate, they can accurately foresee that they are likely to act in ways that have resulted and will continue to result in rejection, rebuff, loss of love, and shame or guilt."[9]

Treatment of hyperkinetic behavior

In treatment of MBD, the stimulant drugs often serve as an



adjunct to other remedial measures (psychological, educational, social). Specifically, they act to help redirect hyperkinetic behavior into controlled, purposeful activity.

Conners observes that "It is definitely the *quality* of activity, not the total *amount* of energy expended, which is changed by these drugs."[10]

According to Wender. "The stimulant drugs are of the greatest practical use in the treatment of the MBD syndrome."[11]

"Because the ages of 5 to 12 are crucial to the child's development and self-image, treatments which permit the child to be more accessible to environmental resources are warranted and useful."[5]

Still, it is important to recognize that the stimulant drugs, including Cylert (pemoline), have limitations and are intended only as adjuncts in an overall treatment program.

Roughly one third of children treated with medication may show no improvement at all. In the remaining two thirds, the improvement may vary from marginal to dramatic. Drugs do not have a direct effect on learning ability, but they can serve to increase attention span and permit the child to attend more purposefully to the world around him.

Long-range considerations

Some investigators feel that failure to take appropriate and adequate therapeutic measures may pose a threat to the future development and well-being of the child.

Wender points to two possible consequences: "(1) the possibility of long-term effects of early psychological deviancy on the child; (2) the possibility of long-term effects of non-treatment on the family."[12]

Sixty-four hyperactive children were restudied five years later at adolescence. "While the hyperactivity had diminished, other handicaps, notably social and intrapsychic* difficulties, attentional, and learning disorders persisted."[13]

Eisenberg observes: "The hyperkinetic syndrome is no mere matter of developmental phase to be endured until it is 'outgrown.' The data from the longitudinal studies reviewed earlier provide evidence for persisting educational handicap and enduring behavior disorder."[8]

1. Wender, P.H., Minimal Brain Dysfunction in Children, Wiley-Inter-science, New York, 1971, p. 1.
2. Masland, R., Testimony before a Subcommittee of the Committee on Appropriations, House of Representatives, 89th Congress, First Session, part 3, Washington, D.C., U.S. Govt. Printing Office, 1965.
3. Stewart, M.A., et al., Am. J. Orthopsychiatry, 36:861, 1966.
4. Huessy, H.R., Acta Paedopsychiatry, 34:130, 1967.
5. Report of the Conference on the use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children, Sponsored by the Office of Child Development and the Office of the Assistant Secretary for Health and Scientific Affairs, Dept. of Health, Education and Welfare, Wash., D.C., Jan. 11-12, 1971.
6. Wender, P.H., Ibid., p. 72
7. Kenney, J.K., et al., Jrnl. of Ped., 79:618, 1971.
8. Eisenberg, L., Pediatrics, 49:709, 1972.
9. Wender, P.H., Ibid., p. 147.
10. Connors, C.K., Jrnl. Learning Disabilities, 4:476, 1971.
11. Wender, P.H., Ibid., p. 93.
12. Wender, P.H., Ibid., p. 128.
13. Weiss, G., et al., Arch. Gen. Psychiatry, 24-409, 1971.

*Within the mind

The diagnosis of MBD

MBD is not uncommon

"Minimal brain dysfunction is probably the single most common disorder seen by child psychiatrists. Despite this fact, its existence is often unrecognized and its prevalence is almost always underestimated."[1]

It has been reported[2,3,4,5] that the hyperkinetic syndrome occurs in 3 to 10 percent of the elementary school population.

MBD most frequently recognized in the classroom

The teacher appears to be the best barometer of change in a school-age child with symptoms of MBD such as hyperactivity. The child, who is usually a male, is generally having both disciplinary and academic problems.

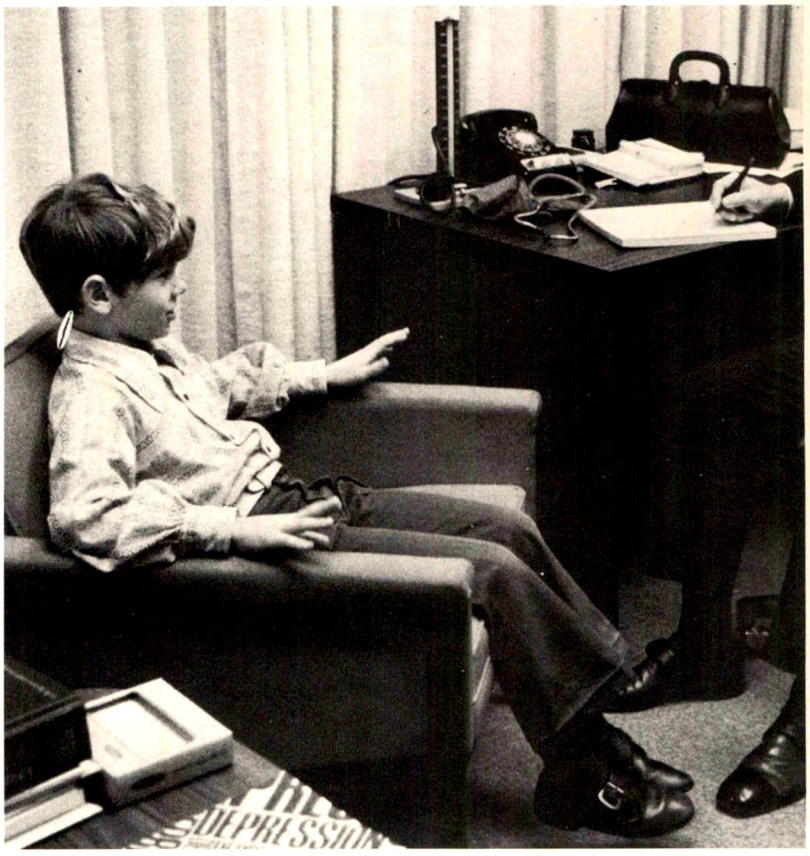
Patient history is diagnostic key

Because the child may function quite normally on a one-to-one basis, when he is receiving extra attention, clinical impressions from a single office visit can be misleading.

". . . I want to re-emphasize that in the practical management—the diagnosis and treatment—of children with suspected MBD, the traditional (neurological) diagnostic measures are of little help."[6]

"The poor correlation of the neurological examination and electroencephalogram with the final diagnosis indicates that these procedures are of limited utility in assessing hyperactivity in childhood."[7]

"The diagnosis of hyperkinetic syndrome is based upon the history and the symptom profile rather than upon special tests or examinations."[8]







The MBD child may not exhibit unusual behavior on the initial office visit. Sometimes, however, subtle signs can be revealing. Note in the photos that the child's hands are in constant motion.



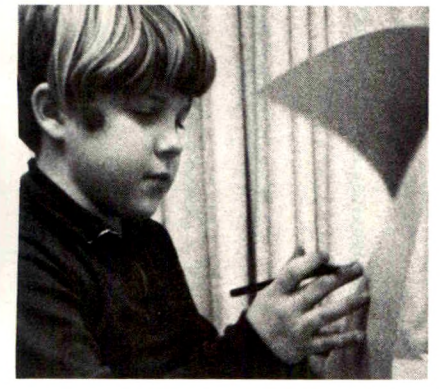
This child is not a model. In all the photos, as in this one, the children are MBD patients, and the adults are health care professionals.

As an adjunct in a treatment program for children with MBD...

ABBOTT INTRODUCES

Cylert®

(pemoline) CIV



An effective aid for transforming undirected hyperkinetic behavior into purposeful activity

Among the noteworthy properties of Cylert (pemoline)

- It is structurally different from the amphetamines and methylphenidate.
- It has shown no evidence of producing tolerance with long-term administration.
- It is taken but once daily, sparing the child the need of mid-day doses at school.
- It has produced significant improvement in behavior according to ratings by physicians, parents and teachers.
- It has shown minimal cardiovascular effects, with little or no effect on pulse or blood pressure.

ABBOTT

Please see last page of this advertisement for Prescribing Information.

The place for Cylert (pemoline) in a treatment program for MBD

The adjunctive use of Cylert
As an adjunct in an overall treatment program, Cylert can increase attention span in the hyperkinetic child and enable him to gain greater control over his actions.

A child successfully treated may show marked improvement in concentration and become more responsive to instruction and counseling.

Typically, the parent or teacher will report fewer emotional upsets and temper tantrums, and far less "squirming" and disruptive motion.

As his attention span improves, the child has less tendency to leave things unfinished. Often in directed activities such as handwriting or drawing exercises, there will be visible improvement in organization.

Cylert in itself will not "enhance learning" or resolve difficult behavioral problems. But it can enable the child—perhaps for the first time—to channel *undirected* hyperkinetic behavior into purposeful activity.

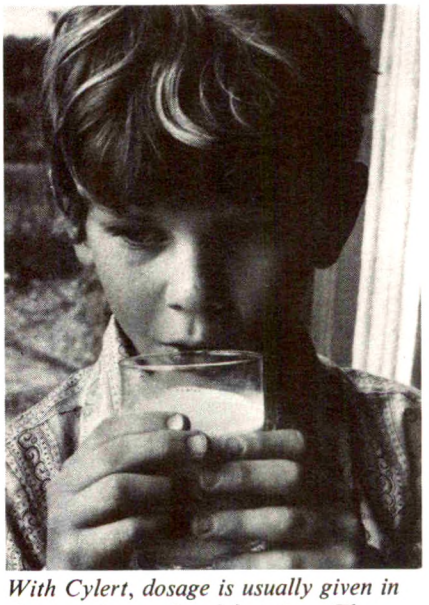
How Cylert differs from other agents
Cylert is a mild central nervous system stimulant which is structurally different from the amphetamines and methylphenidate.

Onset of action
Using the recommended schedule of dose titration, significant benefits may not be seen until the third or fourth week of drug therapy. Side effects may be seen prior to optimum clinical results.

Dosage is taken only once daily
Cylert is usually administered once daily, in the morning.

The importance of single daily dose administration
Among the benefits:

The parent maintains control of medication; there is no need for the child to carry drugs to school.



With Cylert, dosage is usually given in the morning, at breakfast time. There is no need to carry medication to school.

The child is spared the embarrassment of having to "take his medicine" while at school.

There is no continuing reminder to his classmates that he is "different".

There is no need for a nurse or teacher to supervise the taking of a mid-day dose.

Finally, there is no interruption in therapy caused by missed, forgotten or delayed doses.

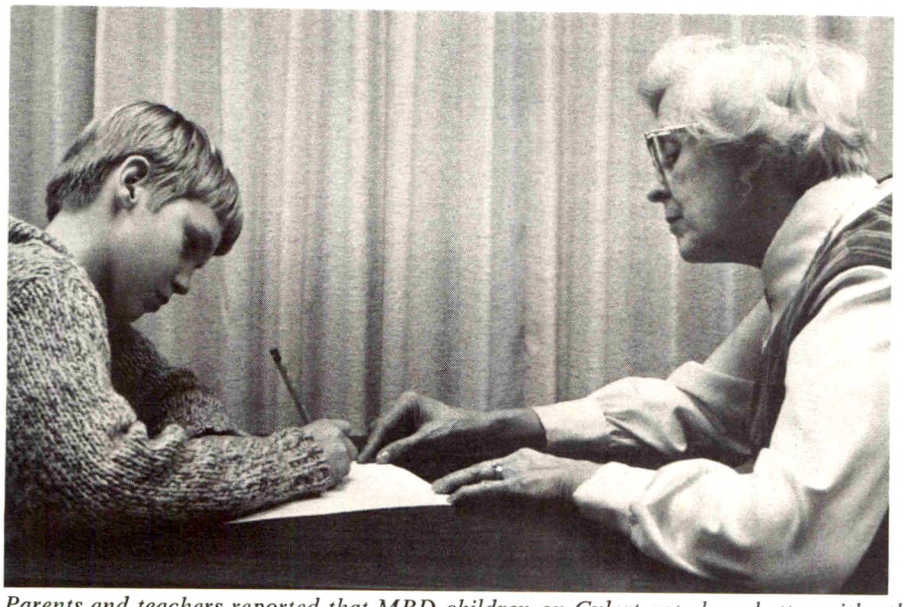
Cylert, alone among CNS stimulants used for treatment of hyperkinetic behavior, is inherently long-acting, permitting once-a-day dosage.

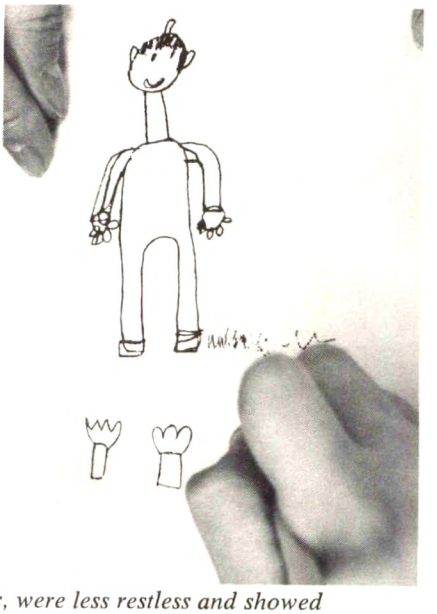
When NOT to use Cylert
Cylert should not be used for (and will not be effective in) simple cases of overactivity in school-age children.

Neither should it be used in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

The physician should rely on a complete history of the child and a thorough description of symptoms from both parents and teacher before postulating a diagnosis of MBD.

Multi-clinic study[1,2] shows significant improvement in children receiving Cylert (pemoline)



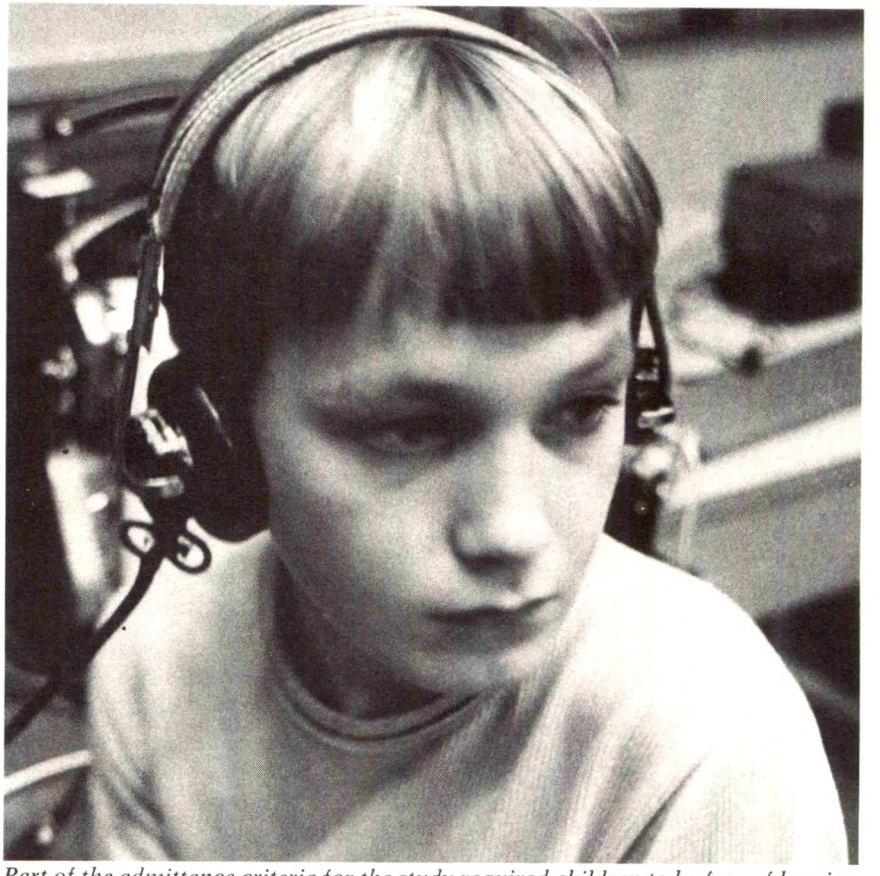


Parents and teachers reported that MBD children on Cylert got along better with others, were less restless and showed less tendency to leave things unfinished. Above: an MBD child (not yet on Cylert) is being given the Goodenough-Harris Draw-a-Person test.

In a double-blind, placebo-controlled study, 238 children, ages six to 12, were treated over a nine week period. *Global (overall) ratings by teachers, parents and physicians were performed at weeks 0, 3, 6 and 9. Parent and teacher ratings showed that Cylert effected significant improvement, compared with placebo, beginning at week three. Physician ratings showed significant improvement beginning at week six.*

Psychological tests

Children on Cylert had significantly higher scores than those on placebo on many of the tests, including the full scale Wechsler Intelligence Scale for Children (WISC) and its Performance IQ Sub-component; the Wide Range Achievement Test (WRAT) (reading and arithmetic); and the Lincoln-Oseretsky Motor Performance Test Factor II.



Part of the admittance criteria for the study required children to be free of hearing or visual defects which might account for learning and behavioral difficulty.

1. Conners, C. K., ed., *Clinical Use of Stimulant Drugs in Children,* Excerpta Medica, 1974, p. 98. 2. Page, J. G., et al., J. Learning Disabilities, 7:498, Oct., 1974.

Please see last page of this advertisement for Prescribing Information.

The parameters of safety of Cylert (pemoline)

FROM MULTI-CLINIC STUDIES (9 WEEKS); SAFETY DATA COLLECTED ON 407 PATIENTS

Parameters studied:

Blood pressure	No difference between Cylert and placebo groups
Pulse	No difference between Cylert and placebo groups
Laboratory tests	No difference between Cylert and placebo groups
Neurological status	No difference between Cylert and placebo groups

Other criteria:

Adverse reactions	Insomnia and anorexia most frequently seen side effects and often improved with continuation of treatment or reduction of dosage. (For other side effects, see Prescribing Information on facing page.)
Weight loss	Mean weight loss of 1.5 lbs. was demonstrated in Cylert group during early weeks of treatment; by 3-6 months, the children returned to the normal weight-curve for their age group.

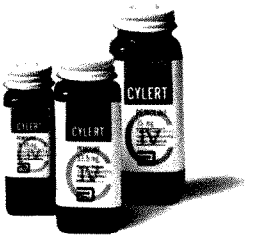
FROM ADDITIONAL STUDIES (LONG-TERM) ON CYLERT (UP TO TWO YEARS AND CONTINUING)

Parameters reviewed:

Mean dosage	Essentially unchanged on mg./kg. basis from original effective dosage.
Blood pressure and pulse rates	Normal in all patients.
Laboratory examination	Mild to moderate increase in transaminase (SGOT and SGPT) levels in a few patients (no clinical symptoms); levels returned to normal on withdrawal of medication. No clinically significant abnormalities in the other tests.

Cylert (pemoline)

Ⓒ Ⓘⓥ



Prescribing Information

Description: Cylert (pemoline) is a white, tasteless, odorless powder which is relatively insoluble (less than 1 mg/ml) in water, chloroform, ether, acetone, and benzene. In 95% ethyl alcohol, the solubility of pemoline is 2.2 mg/ml.

Actions: Cylert (pemoline) is a central nervous system stimulant. The pharmacologic activity of pemoline is similar to that of other known stimulants but with minimal sympathomimetic effects. Pemoline is structurally dissimilar from the amphetamines and methylphenidate. Although the exact mode of pharmacodynamic action is undetermined in man, pemoline has been reported to increase the rate of synthesis of dopamine in rat brain.

In human subjects, Cylert produces peak blood levels within 2-4 hours. The serum half-life is approximately 12 hours. Multiple dose studies in adults at several dose levels indicate that serum levels plateau in approximately three days. Cylert and its metabolites are primarily excreted by the kidneys with approximately 75% of an oral dose appearing in the urine within a 24-hour period. Approximately 43% of pemoline is excreted unchanged. Metabolites include pemoline dione, conjugated pemoline and mandelic acid.

Cylert (pemoline) has a gradual onset of action in children with minimal brain dysfunction. Using the recommended schedule of dosage titration, significant clinical benefit may not be evident until the third or fourth week of drug administration.

Indications: MINIMAL BRAIN DYSFUNCTION IN CHILDREN—as adjunctive therapy to other remedial measures (psychological, educational, social).

Special Diagnostic Considerations: Specific etiology of minimal brain dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis includes the use not only of medical but of psychological, educational, and social resources.

Characteristics commonly reported include: A chronic history of moderate to severe hyperactivity, short attention span, distractibility, emotional lability, and impulsivity. Nonlocalizing (soft) neurological signs, learning disability, and abnormal EEG may or may not be present. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. In the primary therapy of MBD, appropriate educational placement is essential and psychosocial intervention is generally necessary. When these measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

Contraindication: Cylert (pemoline) is contraindicated in patients with known hypersensitivity or idiosyncrasy to the drug. (See PRECAUTIONS)

Warnings: Cylert is not recommended for children under six years of age since safety and efficacy in this age group have not yet been established.

Since Cylert (pemoline) and its metabolites are excreted primarily by the kidneys, caution should be observed in administering the drug to children with significantly impaired renal function.

Sufficient data on safety and efficacy of Cylert administration for periods beyond two years duration in children with minimal brain dysfunction are not yet available. Although a definite causal relationship has not been established, some temporary suppression of predicted growth pattern(i.e., weight and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored.

Drug Interactions: Interactions between Cylert and other drugs have not been studied in humans. As with most other drugs, concurrent administration with other agents, especially drugs with central nervous system activity, should be carefully monitored.

Usage in Pregnancy: Safety for use in pregnancy has not been established. Standard studies of fertility, teratology and reproduction were conducted in rats and rabbits. Daily oral doses of pemoline of 18.75 and 37.5 mg/kg beginning at conception produced no abnormalities in the fetuses and did not affect viability at birth. Further studies using similar dose levels with drug administration beginning 14 days before conception demonstrated an increased incidence of stillbirths in these animals.

Drug Dependence: Studies of the drug abuse potential of Cylert (pemoline) in primates have not demonstrated a potential for self-administration. However, the pharmacologic similarities between Cylert and other CNS stimulants with known abuse liability suggest that drug dependence of the stimulant type might occur. There have been isolated reports of transient psychotic symptoms in adults following long-term misuse of pemoline taken orally in excessive quantities. Therefore, caution should be observed in emotionally unstable patients considered to have a psychological potential for drug dependence.

Precautions: Delayed hypersensitivity reactions involving the liver have been reported in 1-2% of the patients receiving Cylert usually after several months of therapy. No clinical symptomatology has been observed, but mild to moderate increases in transaminase (SGOT and SGPT) levels have occurred in these cases. These effects appear to be completely reversible when drug treatment is discontinued. Transaminase levels should be determined periodically during therapy with Cylert to detect any such reactions.

Adverse Reactions: The most frequently reported adverse reaction with Cylert is insomnia. Insomnia has been observed prior to optimum therapeutic response and in the majority of cases was transient in nature or responded to dosage reduction. Anorexia with weight loss during the first few weeks of therapy has also been reported. With continuing therapy, a return to a normal weight curve usually occurred within three to six months. Other adverse reactions reported include stomachache, skin rash, irritability, mild depression, nausea, dizziness, headache, drowsiness, and hallucinations. Mild adverse reactions appearing early in treatment often remit with continuing therapy. If adverse reactions are of a significant or protracted nature, dosage reduction or discontinuation should be considered.

Dosage and Administration: Cylert (pemoline) is administered as a single oral dose each morning. The recommended starting dose is 37.5 mg per day. This daily dosage should be gradually increased at one week intervals using increments of 18.75 mg until the desired clinical response is obtained. The mean daily effective dose ranges from 56.25 to 75 mg per day. The maximum recommended daily dose of pemoline is 112.5 mg.

Clinical improvement with Cylert is gradual. Using the recommended schedule of dosage titration, significant benefit may not be evident until the third or fourth week of drug administration. Drug administration should be interrupted occasionally to determine if behavioral symptoms sufficient to require continuing therapy recur.

Overdosage: Cylert overdosage has been reported to produce symptoms of tachycardia, hallucinations, agitation, or restlessness. The treatment of acute massive overdosage with pemoline is essentially the same as that for overdosage with any drug having CNS stimulatory effects. Management is largely symptomatic and may include induction of emesis, gastric lavage or other measures as appropriate.

How Supplied: Cylert (pemoline) is supplied as monogrammed, grooved tablets in three dosage strengths:

18.75 mg. tablets (yellow-colored) in bottles of 100 (**NDC** 0074-6025-13)

37.5 mg. tablets (orange-colored) in bottles of 100 (**NDC** 0074-6057-13)

75 mg. tablets (tan-colored) in bottles of 100 (**NDC** 0074-6073-13)

ABBOTT

504070

VALIUM®
(diazepam)
IN THE CONTEXT OF PSYCHOTHERAPY FOR PSYCHONEUROTIC DISORDERS



When predominant anxiety is associated with depressive symptoms in the psychoneurotic patient, the effects may be incapacitating. Feelings of self-esteem seem threatened, and the patient is particularly vulnerable to psychophysiological symptoms affecting the heart, stomach, colon or respiratory tract. Her condition may even interfere with her response to various psychotherapeutic measures. Until the excessive anxiety and its attendant symptoms are relieved, the patient may feel so insecure that she is unable to function.

Often, the patient can't cope with her symptoms while she "works things out"

You may decide that the psychoneurotic patient can benefit from group therapy sessions. However, many patients are uneasy about joining a group, and in the beginning your reassurance and understanding alone may not be enough to help the overly anxious patient face the group. Even though she realizes that she will eventually work through some of the underlying problems, she is experiencing distressing symptomatology that requires more immediate relief. You frequently hear, "What do I do in the meantime, doctor?"



Valium (diazepam) as an adjunct to group therapy—it may have an important role

During psychotherapy for psychoneurotic disorders, Valium offers relief of predominant anxiety and reduces the depressive symptoms often associated with it. The patient generally starts to benefit as early as the first day of therapy, and significant improvement is usually evident within the first few days. Valium is provided in several dosage strengths, so you can precisely control the medication to suit your patient's needs and preclude oversedation or ataxia. If the patient remains symptomatic at bedtime, an *h.s.* dose added to a 2- to 10-mg *b.i.d.* or *t.i.d.* regimen is often very effective. Valium is generally well tolerated and in recommended dosages rarely produces significant untoward reactions, but patients should be cautioned about potentially hazardous activities requiring complete mental alertness, such as driving.

VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets

can reduce predominant anxiety and its associated depressive symptoms

ROCHE

Please see following page for a summary of product information.

VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 100.

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HOMINOLOGY: Psychiatry's Newest Frontier *by* **C. David Jones,** *Chicago Medical School, Chicago, Illinois.* A new and unique method of analyzing behavior through the use of hominology is offered not only to the psychiatrist but also others working in the fields of mental health and human relationships. After demonstrating fallacies in psychotherapies, the author illustrates how this new view of man can be applied with or in place of present psychotherapy methods. The history of hominology is traced from its beginnings in a psychiatric residency program to its current utilization with culturally different children in developing personal dignity. This book is a breakthrough in the field of behavior science in that it successfully combines and integrates mental health, moral value, self-image and sociological adaptation. From this unified approach the author develops new concepts relating moral values to mental health. *'75, 216 pp., 15 il., 2 tables, $12.50*

ABSENTEEISM IN INDUSTRY *edited by* **Stanley F. Yolles, Pasquale A. Carone** *and* **Leonard W. Krinsky,** *all of the State Univ. of New York, Stony Brook, New York. (58 Contributors)* Concerned with the psychiatric/psychological aspects of absenteeism in industry, the first group of papers in this book focuses on the roles of labor, management and the industrial psychologist. Motivational techniques are also discussed at length. The second part concerns itself with the medical/psychiatric viewpoint. The incidence of undetected mental illness is explored and the need for a mental health team in a large corporation is presented, giving both the pros and cons. The family doctor is viewed as an important factor in that he can both help and hinder the overall treatment program. *'75, 164 pp., $11.50*

LEARNING DIFFICULTIES: Causes and Psychological Implications – A Guide for Professionals *by* **Kurt Glaser,** *Univ. of Maryland School of Medicine, Baltimore, Maryland, assisted by* **Susanne Glaser.** *Foreword by* **Leo Kanner.** Intended to condense and interpret the multiple causes of learning difficulties to the many disciplines involved in the education and health care of the child. The reciprocal effects of physical, psychological and educational factors, intelligence, home and cultural environment are pointed out, and the role of the professional is outlined. The chapter "Glimpses into the Future" deals with some possible preventive and therapeutic approaches in years to come. *'74, 112 pp., 2 il., $8.75*

PATIENT POWER: The Development of a Therapeutic Community in a Psychiatric Unit of a General Hospital *by* **Philip M. Margolis,** *Univ. Hospital, Ann Arbor, Michigan. Foreword by* **Maxwell S. Jones.** This text charts a new course for inpatient psychiatric wards in general hospitals. The author relates the intricate details of how one psychiatric unit in a general hospital slowly changed from a traditional therapist-centered unit which stressed the single psychotherapy hour, to a therapeutic community which utilized every hour of the day and every member of the ward. Shared decision-making and responsibility are stressed as an important part in this evolutionary process toward a therapeutic democracy. *'73, 176 pp., $8.95*

NEW TREATMENT APPROACHES TO JUVENILE DELINQUENCY *edited by* **J. L. Khanna,** *Univ. of Tennessee College of Medicine, Memphis, Tennessee. (16 Contributors)* The ideas presented reflect the latest positions held by eminent contributors selected from the fields of psychology, psychiatry, criminology and law. These papers range from a national perspective on juvenile delinquency to a description and discussion of nationally known treatment models as represented by the Janus House for Delinquents, the Achievement Place Model, the Florida Juvenile Rehabilitation Project, Project ACE and the contingency management of delinquent behavior in the community. *'75, 164 pp., 9 il., 12 tables, $11.75*

A HANDBOOK OF NON-VERBAL GROUP EXERCISES *by* **Kenneth T. Morris,** *Central Michigan Univ., Mount Pleasant, Michigan, and* **Kenneth M. Cinnamon.** *Foreword by* **Goodwin Watson.** This type of manual will facilitate fresh inventions and suggestions. The authors emphasize that nonverbal exercises are not ends in themselves but tools to achieve improved behavior. This volume promotes rapid discovery of specific exercises with material organized under such headings as relaxation, trust, frustration, rejection and sensory awareness. All exercises are described in a standardized format. Asterisks show the more dynamic exercises with above-average potential for achieving goals. The importance of the subsidiary goals of an exercise is stressed. *'75, 324 pp., 28 il., cloth-$14.75, paper-$10.95*

LIVING OR DYING: Adaptation to Hemodialysis *edited by* **Norman B. Levy,** *State Univ. of New York, Brooklyn, New York. Introduction by* **Belding H. Scribner.** *(13 Contributors)* This book, the first devoted to the psychological aspects of hemodialysis, presents studies by leading authorities on the major problems in psychological adaptation to this procedure. Included are the special psychiatric problems of the child receiving hemodialysis, the uncooperative hemodialysis patient, psychological factors determining survival, and changes in sexual activity in hemodialysis and transplantation. Also presented are the proceedings of a panel held at the 1972 meeting of the American Psychiatric Association. *'74, 164 pp., 34 tables, $10.75*

REFERRING THE PSYCHIATRIC PATIENT: A Guide for the Physician *by* **Larry R. Kimsey** *and* **Jean L. Roberts,** *both of The Univ. of Texas, Dallas, Texas.* This text provides practical and concrete information about psychiatry and the mechanics of referral including the intricacies, difficulties and techniques. The fact that psychiatric and clinical physicians need to work more closely is emphasized, as interprofessional friction frequently arises. What these differences are and how they can be successfully dealt with is fully explained in this text. Selection of the patient for referral, types of available somatic and non-somatic therapies, selection of the psychiatric facility, and appropriate referral techniques are discussed. *'73, 100 pp., $6.95*

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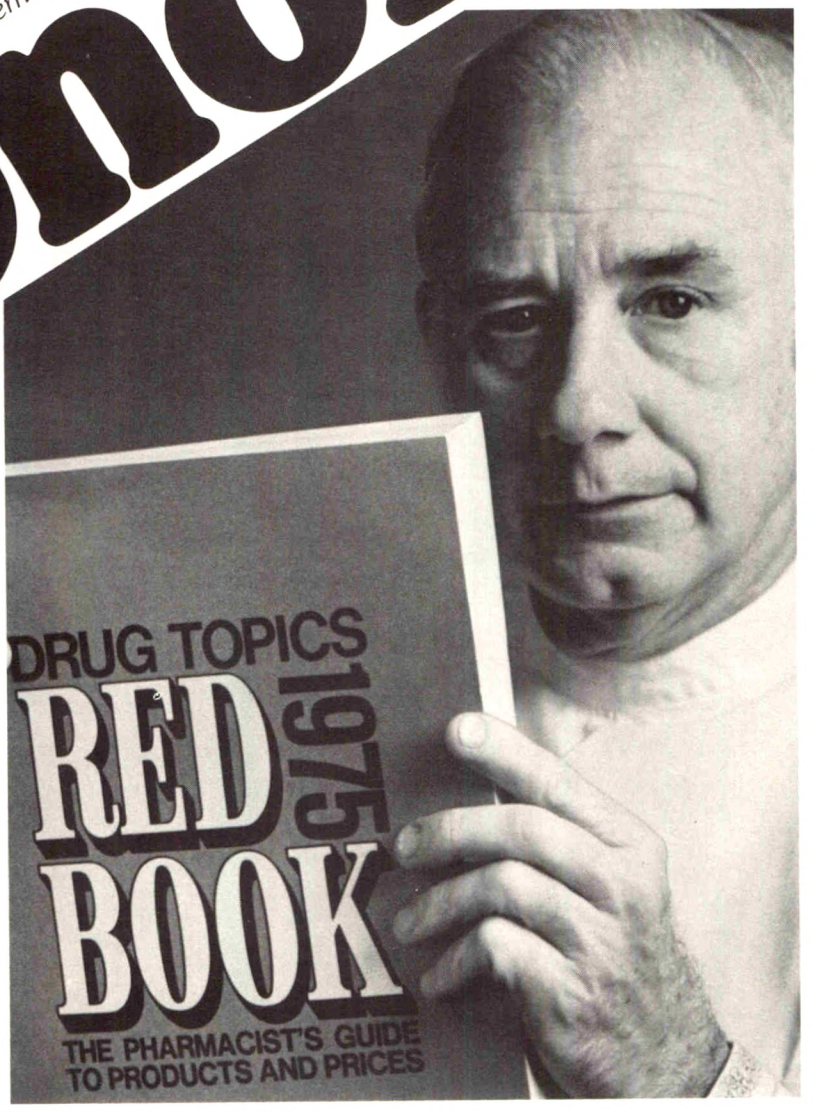


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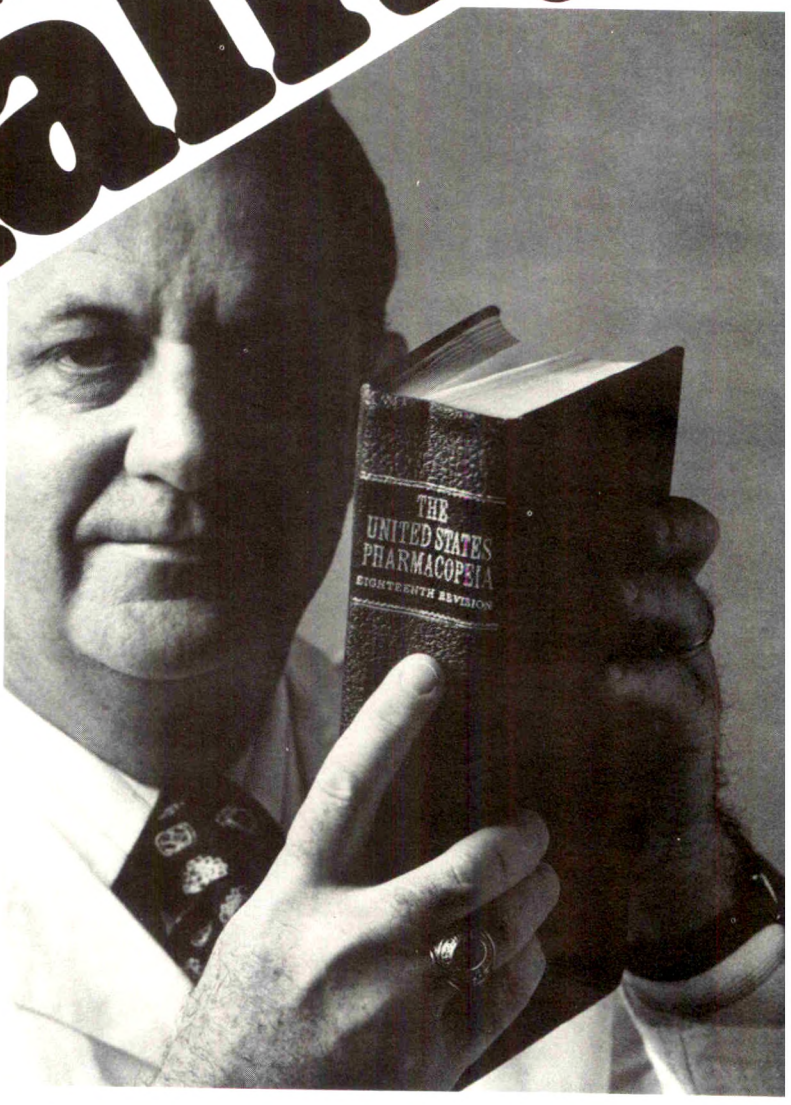
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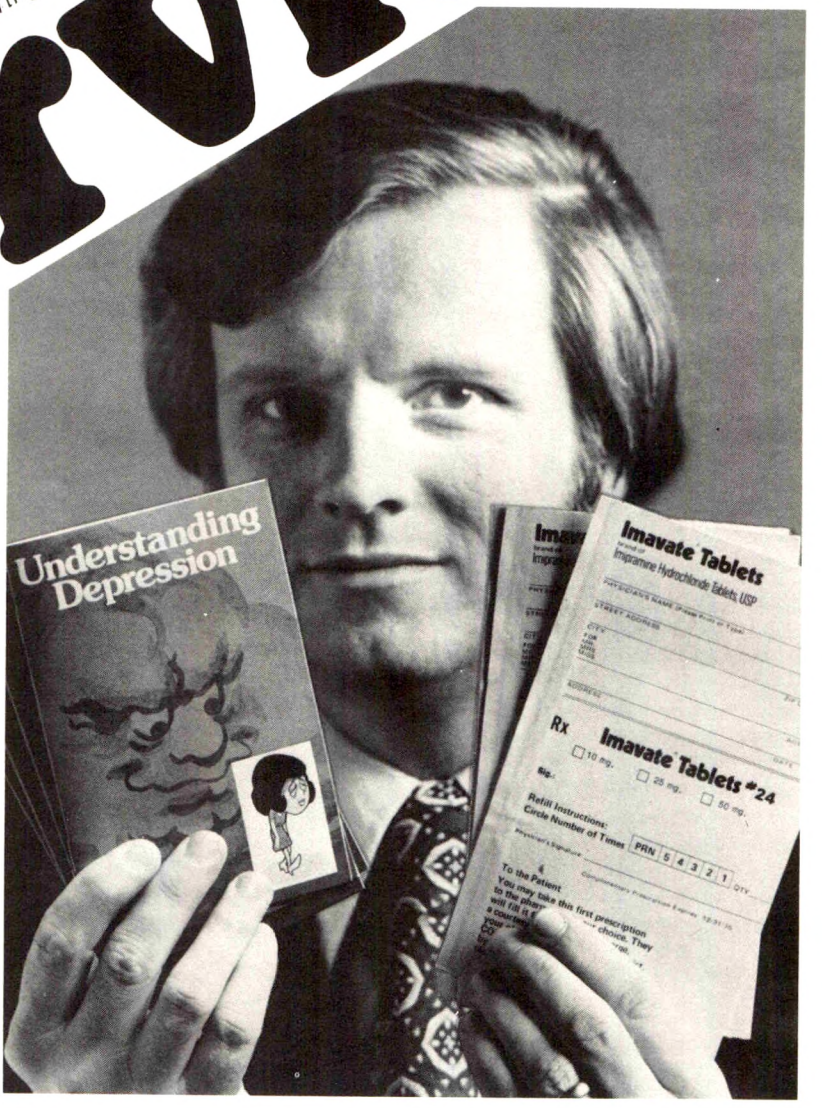
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Prescribing Information:

Indications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than other depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious or even fatal. When it is desired to substitute imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine hydrochloride during pregnancy and lactation has not been established; therefore, this drug should be administered to women who are or who might become pregnant, or to nursing mothers, only when the potential benefits clearly outweigh possible hazards. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed. Animal reproduction studies with imipramine HCl have yielded inconclusive results. Oral studies in rats and mice at doses up to 2½ times, and in rabbits at doses up to 25 times the maximum human dose, showed no clear evidence of teratogenic potential, but subcutaneous studies showed a teratogenic effect in rabbits and equivocal teratogenicity in mice at respective doses up to 5 and 6½ times the maximum human dose. Increased resorptions and stillbirths and decreased neonatal weights were seen in the oral as well as subcutaneous studies.

Extreme caution should be used when this drug is given to:

- patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- patients receiving guanethidine or similar agents since imipramine hydrochloride may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, this drug is not recommended for use in patients under twelve years of age.

Since this drug may impair the mental and/or physical abilities required for the performance of tasks such as operation of an automobile or hazardous machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with imipramine hydrochloride and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine hydrochloride may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine hydrochloride with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine hydrochloride is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety,



Imavate®
imipramine hydrochloride
tablets, USP 10 mg, 25 mg, 50 mg

restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; cnstipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever or sore throat during therapy: the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breas largement and galactorrhea in the female; increased creased libido, impotence; testicular swelling; elevati depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altere function; weight gain or loss, perspiration; flushing; u frequency; drowsiness, dizziness, weakness and fa headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative diction, abrupt cessation of treatment after prol therapy may produce nausea, headache and malais

Dosage and Administration: Lower dosages are r mended for elderly patients and adolescents. Lower d are also recommended for outpatients as compared t pitalized patients who will be under close supervisior age should be initiated at a low level and increased ally, noting carefully the clinical response and any ev of intolerance. Following remission, maintenance m tion may be required for a longer period of time, at the dose that will maintain remission.

Oral: *Usual Adult Dose: Hospitalized patients*—I 100 mg/day in divided doses gradually increased mg/day as required. If no response after two weeks, ir to 250-300 mg/day.

Outpatients—Initially, 75 mg/day increased mg/day. Dosages over 200 mg/day are not recomm Maintenance, 50-150 mg/day.

Adolescent and geriatric patients—Initially, mg/day; it is generally not necessary to exceed 100 m

Overdosage: *Symptoms:* These include drow stupor, tachycardia, ataxia, vomiting, cyanosis, hy sion, shock/coma, restlessness, agitation, hyperpyre vere perspiration, hyperactive reflexes, muscle athetoid movements, convulsions, mydriasis. There cardiac arrhythmia, EKG evidence of impaired con and signs of congestive heart failure.

Treatment: There is no specific antidote. I emesis and gastric lavage are recommended. It helpful to leave the tube in the stomach, with irrigat continual aspiration of stomach contents, possibly ing more rapid elimination of the drug from the bo room should be darkened, allowing only a minimal of external stimulation, to reduce the tendency to sions.

1. Hyperirritability and convulsions have bee cessfully treated with parenteral barbiturates in sev stances. However barbiturates should not be empl drugs that inhibit monoamine oxidase have also bee by the patient in overdosage or in recent therapy. Si barbiturates may induce respiratory depression, part in children. It is therefore advisable to have equipmer able for artificial ventilation and resuscitation when b rates are employed. Paraldehyde has been used eff in some children to counteract muscular hypertor convulsions without causing respiratory depression. data indicate that an internuncial neuron blocker, methocarbamol, may be an effective treatment for sions and muscular hypertonus.

2. Shock (circulatory collapse) should be treat supportive measures such as intravenous fluids, and corticosteroids.

3. Hyperpyrexia should be controlled by w means available, including ice packs, if necessary.

4. Signs of congestive heart failure have been torily treated by rapid digitalization.

5. If an extremely large overdose has been i use of the artifical kidney may be helpful in elimina drug from the body. However, due to low plasma the drug and a high rate of secretion in the stomach that a more efficient technique is continuous gastric

How Supplied: Imavate Tablets, brand of Imi Hydrochloride Tablets, USP (film-coated), 10 mg (bottles of 100 (NDC 0031-5610); 25 mg (coral) i of 100 and 1000 (NDC 0031-5625); and 50 mg (fu bottles of 100 and 1000 (NDC 0031-5650). Ju

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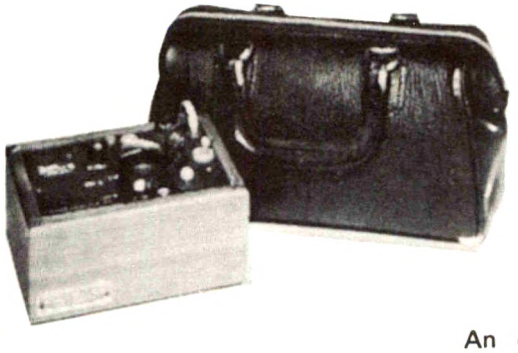
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(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic patients

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides; carefully consider benefit versus risk in less severe disorders. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy, observed primarily in patients receiving larger than recommended doses, is characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision; the possibility of its occurrence may be reduced by remaining within recommended dosage limits. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; rarely, nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—Rare cases described as parotid swelling. The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

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The Depot Fluphenazines: A Reappraisal After 10 Years' Clinical Experience

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The author reviews the information gathered during the past 10 years of clinical experience with depot fluphenazines. He details the types of patients who are most likely to benefit from therapy with injectable drugs, the techniques of this therapy, the therapeutic efficacy and side effects of the drugs, and how they interact with other medications. Although he concludes that depot fluphenazines are safe and effective, he cautions clinicians that the starting dose and the intervals between injections must be carefully selected for each patient and that such factors as age, physical condition, diagnosis, and drug history must be taken into consideration.

PSYCHIATRY HAS EXPERIENCED a number of significant advances in this century, including the development of psychopharmacotherapy, the effectiveness of which depends on a variety of factors. One of the most important of these factors is the actual ingestion of adequate doses of pharmacotherapeutic drugs by patients.

Unfortunately, despite ample evidence that improvement can be achieved and sustained by the taking of an antipsychotic such as a neuroleptic or lithium for as long as it is required and despite all of our efforts, a large number of patients, particularly schizophrenic patients, will not take medication regularly after release from the hospital. We are therefore faced with a merry-go-round kind of process created by the discharges and readmissions of patients whose maintenance medication outside of the hospital has been reduced to inadequate levels or discontinued.

In every psychiatric hospital there are patients who could be released if they could be relied on to take medication. It has been estimated that 20 percent or more of hospitalized patients fail to take their drugs consistently despite supervision, thereby impeding their rehabilitation. These drug defectors constitute a large segment of the world's psychiatric population. They have been and are a major therapeutic challenge.

What has been needed for patients who patently require chemotherapy but are unreliable drug takers has been a long-acting depot injectable neuroleptic. Such a preparation would remove responsibility for taking medicine from patients unable to assume it. This would assure physicians that patients are getting their medication and enable them to return more patients to the community and to keep them there. The development of fluphenazine enanthate, fluphenazine decanoate, flupenthixol decanoate, perphenazine enanthate, fluspirilene, pipothiazine undecylenate, and pipothiazine palmitate[1] has made this possible—a most important step forward in the treatment of certain psychiatric patients.

The first of the depot neuroleptics were fluphenazine enanthate and fluphenazine decanoate. These preparations have been administered to thousands of patients throughout the world during the past 10 and 9 years, respectively. Patients have had injections of various doses of these drugs at intervals ranging from a few hours to 8 weeks; some patients have received depot fluphenazines continuously for as long as 7 years. The information garnered from this vast clinical experience is the subject of this review.

CLINICAL INDICATIONS

Until the safety and efficacy of the depot fluphenazines could be established, the early clinical trials of these compounds were restricted to physically healthy hospitalized chronic schizophrenic patients between 20 and 50 years old who were receiving oral fluphenazine. The results of these trials (1–8) verified that the depot fluphenazines were efficacious and safe for a substantial percentage of

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[1]Fluspirilene, pipothiazine undecylenate, and pipothiazine palmitate are currently available only in Europe. They are under clinical trial in the United States.

these carefully selected patients. Consequently, pioneers in the use of these preparations gradually included in their patient populations chronic schizophrenic patients who had a variety of physical disorders and who were being treated with all types of oral neuroleptics.

Clinical experiences with these patient populations substantiated that it is not absolutely necessary to treat a patient with oral fluphenazine before switching to a depot fluphenazine (1–8), that a depot fluphenazine can be given safely to many schizophrenic patients with diverse physical illnesses (9), that there are few adverse interactions between the depot fluphenazines and a large number of other medications patients often must take (9), and that individuals unresponsive to or intolerant of another neuroleptic may respond optimally to a depot fluphenazine with few or no severe side effects (1–8). Thus the number of potential candidates for this form of therapy was broadened considerably.

Encouraged by these clinical facts, researchers then began to administer depot fluphenazines to outpatients and to cautiously prescribe these drugs for hospitalized schizophrenic patients whose ages were in the 60s and 70s. Initially, the group of outpatients included only those released from the hospital after treatment with a depot fluphenazine had been started and who were on maintenance fluphenazine enanthate or on fluphenazine decanoate therapy. As experience with this population grew and clinicians became more secure in their use of these preparations, they began to give them to chronic schizophrenic outpatients receiving maintenance therapy with all oral neuroleptics. The results obtained in the two groups of outpatients were sufficiently satisfactory that the number of patients so treated increased annually. By 1974 the majority of patients receiving depot fluphenazine therapy were outpatients being treated in clinics and in the offices of private practitioners.

The preliminary experiences with depot fluphenazines in geriatric patients suggested that many of them not only may respond well to these formulations but that they tolerate adjusted individualized doses as well as younger patients do. Furthermore, since a high percentage of elderly schizophrenic patients also have physical disorders that require pharmacotherapy, experience with them provided additional data indicating that almost any drug may be prescribed with the depot fluphenazines with little or no risk of harmful potentiation or other forms of adverse interactions. Subsequently, more and more geriatric schizophrenic patients, including a small number in their 80s, have been and are being treated with depot fluphenazines both in and out of the hospital (10–15).

Among the schizophrenic outpatients receiving maintenance depot fluphenazine therapy, some failed to return for further injections. The majority of these subsequently relapsed, some so badly that rehospitalization was mandatory. At the time of readmission these patients were again given either fluphenazine enanthate or fluphenazine decanoate immediately. Experience with these patients quickly taught clinicians that patients usually respond to a depot fluphenazine in the same way they had previously. It also stimulated some therapists to reinstitute depot fluphenazine therapy promptly in relapsing outpatients in an effort to preclude hospitalization. These clinicians soon learned that quick readministration of proper doses of a depot neuroleptic can produce sufficient symptom amelioration to obviate the need for rehospitalization.

Because those patients who relapsed clinically after discontinuing depot fluphenazine injections became comparable in many respects to acute schizophrenic patients, and because retreatment with a depot fluphenazine often produced prompt control of the most disturbing symptoms, a few psychiatrists concluded that it might be possible to treat newly admitted acutely schizophrenic patients with a depot fluphenazine. This was tried first with fluphenazine enanthate and later with the decanoate. However, either because of uncertainty about the efficacy of a long-acting injectable drug for an acute psychotic episode or because of the assumption that more antipsychotic effect is needed than can be provided by the depot neuroleptic alone during the crucial acute period, clinicians treated these patients with a depot fluphenazine along with oral antipsychotic drugs.

Combined depot and oral neuroleptic treatment for acute schizophrenia proved to be efficacious and generally better than treatment with an oral neuroleptic alone. It also stimulated Chien and Cole to do an uncontrolled study of fluphenazine enanthate in the treatment of acute schizophrenic episodes. These investigators reported (16) that the results of their uncontrolled study led them to suspect that "a long-acting injectable drug, administered alone, is a satisfactory medication regimen for the management of acutely psychotic patients." To verify this, they designed a controlled study (16) to test the relative efficacy of fluphenazine enanthate alone, chlorpromazine alone, and a combination of the two treatments in newly admitted acutely psychotic patients. This study demonstrated that fluphenazine enanthate alone "is a useful and effective agent in the treatment of newly hospitalized acutely psychotic patients" (16).

The results of this study enlarged the scope of candidates for depot fluphenazine therapy because they verified that these preparations can be used to treat not only chronic but acute schizophrenia as well as acute psychoses of diverse etiologies. This study did much to encourage other clinicians to treat a variety of acute psychoses, including hypomania and mania, with depot fluphenazines. The therapeutic results they have obtained have demonstrated further that properly selected patients with acute psychosis can be treated effectively and safely with a depot fluphenazine without first having to be stabilized by one of the oral neuroleptics (10, 17–19).

The depot fluphenazines have also been administered to some children and to a few adults with severe psychoneuroses (20). Because of the small number of subjects and the short duration of treatment in this study, additional trials in children and nonpsychotic adults are imperative before a definitive assessment can be made of the benefits and liabilities of depot fluphenazines for these patients. Until these are completed, and the data from

them are critically evaluated, the depot fluphenazines are not recommended for children and nonpsychotic adults because safe and effective conditions for their use in these individuals have not been established.

To sum up the clinical indications for the depot fluphenazines, it can be stated that the prime candidates for these compounds are chronic schizophrenic patients (not only those who are unreliable drug consumers) either in or out of the hospital, followed by newly admitted acute schizophrenic patients. Patients with other acute psychoses may also respond to depot fluphenazine therapy, providing they are judiciously selected for the depot neuroleptic alone or in combination temporarily with an oral neuroleptic. Furthermore, clinical experience to date has shown that just as the scope of candidates with various degrees of psychopathology has been extended, so too has the age spectrum broadened from adolescents to geriatric patients in their 80s.

TECHNIQUE OF THERAPY

During the early trials of fluphenazine enanthate and fluphenazine decanoate, when they were being evaluated in chronic schizophrenia, the majority of patients received an injection of 25 mg of the enanthate every two weeks or 25 mg of the decanoate every two to three weeks. These starting doses and intervals between injections produced satisfactory therapeutic results in a sufficiently large number of patients that they are now recommended by the manufacturer of these drugs. However, after more than a decade of experience, it is an indisputable fact that the starting dose and the intervals between injections must be carefully selected for each individual and that such factors as age, physical condition, the nature and severity of the illness, and the drug history of the patient and his family must be taken into consideration. If this is not done, the risk of over- or underdose is great.

Although some therapists contend that all chronic patients should have a trial on oral fluphenazine before starting treatment with the depot form, as mentioned earlier, this is not absolutely necessary. What is necessary is that the therapist be thoroughly familiar with the patient's personal and family drug histories. If these reveal that the patient or a first-degree blood relative has had a neuroleptic-induced extrapyramidal reaction, especially one caused by one of the weaker neuroleptics such as thioridazine, the patient is at high risk of having a neurologic response to a depot fluphenazine.

In the event the patient does have a positive drug history, it is prudent to initiate depot fluphenazine therapy with a test dose of .1 cc (2.5 mg). This dose is usually very well tolerated; if it is, the dose can be increased at short intervals until the individual's requirements have been met. For example, some therapists give .1 cc of the drug on days 1, 3, 5, and 8; .2 cc on day 12; .5 cc on day 19; and 1 cc on day 26. Thereafter, 1 cc or more is given every 14 days for several months. During this time clinical effects are weighed against side effects (10). If the patient has been receiving relatively high doses of an oral neuroleptic, some therapists begin depot fluphenazine therapy with .2 to .5 cc and gradually increase the subsequent doses, which are injected at varying intervals according to the patient's response.

To minimize the risk of inadvertent overdose and severe side effects, especially extrapyramidal reactions, at the outset of depot fluphenazine therapy for chronic patients being switched from oral neuroleptics, it is my policy to first have the patient on a drug holiday for at least a week and then to give .1 cc of the enanthate or the decanoate. The risk that a patient will relapse during such a short drug holiday is minimal. Fortunately, relapse is seldom precipitous. Rather, it evolves slowly so that early detection is possible. The prompt administration of even .1 cc of a depot fluphenazine can provide some symptom relief. Further symptom control can be obtained by additional injections of escalating doses at short intervals.

In my experience, this method of initiating depot fluphenazine therapy is practical and very safe because it seldom results in very troublesome side effects. It must be remembered that during oral neuroleptic treatment the patient's tissues have been saturated with the neuroleptic and that the accumulations of the parent compound and its metabolites are slowly released and excreted. Consequently, to start depot fluphenazine therapy without a drug holiday is to superimpose the fluphenazine on the accumulated oral neuroleptic. This can and often does result in an extrapyramidal reaction or other symptoms of overdose, particularly when the first injection contains 25 mg or more. I am convinced that a substantial number of the adverse reactions noted in the beginning of depot fluphenazine treatment are a direct consequence of initiating therapy with too high a dose. These reactions can be precluded by giving low doses of the drug initially to a chronically ill person for whom there should be no rush to achieve an optimal therapeutic response.

Depot fluphenazine therapy for acute patients (those with schizophrenia, mania, etc.) should also be instituted with low doses (.2–.5 cc). Increasing doses can then be repeated daily for several days, in some cases supplemented with daily doses of an oral neuroleptic. After symptom control has been achieved, the dose of the depot fluphenazine and the interval between injections must be adjusted to the individual needs of the patient to avoid subsequent overdose and troublesome adverse reactions.

Depot fluphenazine therapy for chronic patients over the age of 50 should also be initiated with a .1 cc dose. The older the patient, the less tolerant of oral and depot neuroleptics he is likely to be. The risk of neuroleptics causing extrapyramidal reactions is highest in the geriatric population. Consequently, it is imperative that elderly patients not be given high doses of a depot fluphenazine at the beginning of therapy. The majority of these older patients are best treated with low doses at short intervals, for example, .1–.2 cc every week or 10 days, rather than higher doses at two- to three-week intervals.

In contrast to chronic schizophrenic patients who are responsive to low or moderate doses of a depot fluphenazine are the sizable number who do not benefit from the

usual doses of depot neuroleptics. Many therapists, especially in Europe, have begun to use high-dose depot fluphenazine therapy for chronic schizophrenic patients who would be prisoners of psychosis indefinitely without such treatment. In recent years an escalating number of patients have been and are being treated with gradual increments of a depot fluphenazine to doses ranging from 100 to 500 mg (10, 17, 21). Those experienced with high-dose depot fluphenazine therapy testify that it is remarkably safe and that it does not cause a significantly higher incidence of extrapyramidal reactions than low-dose therapy.

Nevertheless, high-dose therapy is not without risk. It should be reserved for those chronic schizophrenic patients most likely to benefit from it, namely, physically fit patients under the age of 40 with an acute onset rather than a slow evolution of their psychosis who have been ill for less than 10 years, who have had some response to neuroleptic therapy, and who are still reacting with affect to their delusions and hallucinations rather than accepting them complacently. When maximum improvement is reached in these patients, which may not happen for four to six months, the depot fluphenazine should be reduced gradually to the lowest effective individual maintenance dose.

Short-term high-dose depot fluphenazine therapy has been and is being used effectively for the treatment of acute schizophrenic, manic, and other severely disturbed psychotic patients with moderate to marked agitation. Ropert and associates (17), for example, reported that they treated acute manic patients whose ages ranged from 27 to 62 with 75 to 300 mg of fluphenazine enanthate or with 100 to 300 mg of fluphenazine decanoate. Bakke (10) reported that 30 acute patients were treated with 200 to 500 mg (usually 200 to 250 mg) of fluphenazine enanthate.

There is an art of pharmacotherapy with depot fluphenazines. It includes the injection of the lowest effective dose as infrequently as possible. This means that patients should not routinely receive the same dose at fixed intervals but progressively lower doses at widening intervals. Those who practice this art are administering adjusted individualized doses at intervals ranging from five days to eight weeks.

THERAPEUTIC EFFICACY

That depot fluphenazines are effective antipsychotic agents that are particularly useful for maintenance therapy was recognized over a decade ago. Nevertheless, some psychiatrists have questioned whether it is the active medication or other factors that account for benefits enabling patients to remain out of the hospital. It seemed essential, therefore, that a careful double-blind, controlled trial be carried out with prospective clinical and social evaluations to determine definitively whether active medication makes a difference in a group of chronic patients. Such a trial has been completed by Hirsch and associates (22) in England. They systematically screened the notes of all outpatients on receiving fluphenazine depot injections at two London hospitals, including in their study all of the patients for whom there was evidence in their history for a diagnosis of schizophrenia. They also included patients with a history of paranoid delusions or hallucinations with depressive symptoms but no first-hand schizophrenic symptoms.

On the basis of their results, these investigators stated,

> The injections of fluphenazine decanoate in small monthly doses confer a considerable degree of protection to chronic schizophrenics living in the community by preventing relapse, which usually means a reemergence or definite increase of florid schizophrenic symptoms. This is a specific drug effect not conferred by simply attending a "fluphenazine depot clinic" without getting active medication. Our sample was representative of the kind of patient likely to be treated in such a clinic. For such a group of patients already established on a maintenance regimen of depot fluphenazine, depression is no more a problem than for patients taken off the drug. (22)

This is one of many controlled trials substantiating the therapeutic efficacy of the depot fluphenazines, which have also been compared in controlled trials with all other depot neuroleptics (10, 12, 21, 23, 24). The results of these studies have provided additional evidence of the efficacy of the depot fluphenazines. In Europe, patients have even been switched from other depot neuroleptics to the depot fluphenazines (10, 12, 21). In some cases, the response to the depot fluphenazines was better, in others equal to, and in a small number not as good as the response to the previous depot neuroleptic.

SIDE EFFECTS

Lambert and Midenet (25) aptly pointed out,

> [There] is a pathology of neuroleptic therapy, irrespective of the disease treated. The side effects of depot neuroleptics are not ascribable to the drug alone. They also depend on the patient and his constitution. Multiple convergent factors lead to their development and make medical surveillance an indispensable supplement to the pharamcological control.

An analysis of the published reports on fluphenazine enanthate and fluphenazine decanoate verifies that they are capable of causing minor autonomic side effects, infrequent hypotensive episodes, and sporadic dermatologic disorders. Generally, these have been mild and not severe enough to discontinue treatment. They usually subside spontaneously as treatment with the same dose of the drug is continued or after the dose is reduced. Disturbances of menstruation, including amenorrhea, and galactorrhea have been noted during depot fluphenazine therapy. These endocrine effects disappear after the dose is reduced or treatment is discontinued.

To date there has not been a report of jaundice or agranulocytosis during depot fluphenazine treatment. Fluphenazine enanthate and fluphenazine decanoate have been given to many patients with varying degrees and

types of liver pathology without adverse consequences. The continuous administration of each of these depot neuroleptics, even in very high doses, for months and years has not resulted in clinical or laboratory evidence of hepatotoxicity. Fluctuations in the leukocyte count have occurred in patients receiving depot fluphenazines, just as they have in patients treated with oral neuroleptics. These are independent of the drug. Thus it can be said that even prolonged administration of depot fluphenazines is not likely to have adverse effects on the hematopoietic system.

Because ocular and dermatologic changes have occurred in some patients receiving certain phenothiazines (chloropromazine, levomepromazine, and thioridazine) over a long period or in very high doses, it should be noted that there has not been a report in the medical literature of the depot fluphenazines causing skin or eye changes (9). In fact, these drugs have been administered to patients with lens and corneal opacities and/or skin pigmentation caused by other phenothiazines without worsening either condition.

Depending on dose and individual susceptibility, some patients experience varying degrees of drowsiness and lethargy after an injection of the enanthate or the decanoate. As a rule these reactions occur after the initial injection. Generally they are mild, do not require counteracting medication, and abate spontaneously within a week. Should these pharmacologic effects be pronounced, they can usually be mitigated or abolished by 10 or 20 mg of methylphenidate once or twice daily for a few days after the injection of fluphenazine. Sometimes several cups of coffee provide enough stimulant to overcome these reactions.

Extrapyramidal Reactions

Among the neurophysiologic effects of oral and depot neuroleptics are diverse signs and symptoms of extrapyramidal reactions, such as akinesia, dyskinesia, akathisia, tasikinesia, oculogyric crises, belphorospasm, and parkinsonism. It is widely believed that fluphenazine enanthate and fluphenazine decanoate (and all other depot neuroleptics) have a greater tendency to evoke various extrapyramidal reactions than oral neuroleptics. This is an erroneous assumption. It has not been proved by well-designed, rigidly controlled, and well-executed comparative studies.

The published studies comparing the depot fluphenazines with oral antipsychotic drugs, when analyzed in total, indicate that these drugs are no more liable to evoke striopallidal symptoms than other potent oral or depot neuroleptics. However, data from comparative studies by Itil and Keskiner (26) in the United States and by Van Praag and Dols (27) in Europe suggest that the incidence of neurologic reactions caused by the decanoate is somewhat less than that caused by the enanthate. Likewise, the relationship between the sex and age of patients and the incidence of the different types of neurologic side effects caused by fluphenazine enanthate and fluphenazine decanoate is the same as it is with the oral neuroleptics.

The time of onset of each of the extrapyramidal reactions induced by fluphenazine enanthate and fluphenazine decanoate differs significantly from the time of onset of these same reactions elicited by the potent oral neuroleptics. Whereas 90 percent of the dyskinesias, 90 percent of the cases of parkinsonism, and 90 percent of the akathisias caused by oral neuroleptics develop in the first 4½ days, 72 days, and 73 days, respectively, 90 percent of each of these reactions due to fluphenazine enanthate or decanoate appear as follows: dyskinesia, 12 to 24 hours after injection; akathisia, one to four days after injection; and parkinsonism, two to five days after injection (9).

Because of the dramatic onset of depot-neuroleptic-induced striopallidal reactions, especially the dyskinesias, some clinicians think these are more severe than those caused by the oral neuroleptics. Whether this is factual or not is uncertain at this time. I am unaware of any study that provides data permitting a definitive conclusion about this.

Since the depot fluphenazines can evoke extrapyramidal reactions, can they be prevented or modified by the prophylactic administration of an antiparkinson agent? The answer is no. In the study by Chien and Cole cited earlier (16), five days of antiparkinsonian medication following each injection of fluphenazine enanthate was prescribed because of the common clinical observation that most of the extrapyramidal episodes occurred during the first few postinjection days. The results observed, however, did not suggest any useful prophylactic effect. These investigators reported (16) that they had also compared three groups who were all receiving fluphenazine enanthate. One of these groups received antiparkinsonian medication daily, one received antiparkinsonian medication for five days after each injection of fluphenazine enanthate, and one received antiparkinsonian medication as needed. The authors concluded that "this study also failed to support the validity of prophylactic use of antiparkinsonian medication."

The results of these and other studies confirming that antiparkinsonian drugs do not have a prophylactic effect against neuroleptic-elicited extrapyramidal reactions argue against giving these drugs to patients receiving a depot neuroleptic. They should be prescribed only to treat emergent extrapyramidal symptoms.

Akinesia. When treatment with fluphenazine enanthate or fluphenazine decanoate is started, some patients develop mild to moderate degrees of akinesia, characterized by weakness and muscular fatigue. This causes the patient to be almost constantly aware of fatigue in a limb used for ordinary repetitive motor acts, such as walking or writing. In the advanced form of the reaction, the patient complains of aches and pains in the musculature of the affected limb. This may be associated with joint pains, most often in the shoulder, and limitation of motion. Patients with akinesia seem apathetic; they are disinclined to initiate or expend the energy to complete a task. There is thus a reduction in their voluntary activity. This can mimic the drug-induced lethargy and drowsiness discussed above.

This neurologic reaction is not relieved by methylphenidate, but it is very responsive to antiparkinsonian

medication (e.g., 2 mg of biperiden). Should medication be indicated, it usually has to be prescribed for only a few days because even untreated akinesia tends to wane progressively in the first week after injection of the depot fluphenazine. This syndrome tends to be most pronounced during the first months of treatment and to fade out gradually as injections are continued. Because akinesia can interfere with work and other activities, it is advisable that whenever possible a depot neuroleptic should be administered late in the day preceding the day(s) the patient does not have to work.

Akathisia. Some patients develop mild akathisia immediately after an injection. This manifests itself by muscle cramps and some insomnia. Since this is a striopallidal reaction, it can be managed easily by an antiparkinsonian drug. It also can be eased by the administration of an antihistamine such as diphenhydramine hydrochloride, which has both antiparkinsonian and hypnotic effects, at bedtime. Seldom is it necessary to prescribe counteracting agents for more than a week after the injection of fluphenazine.

Akathisia is often described by the patient as the jitters. Moderate to severe forms of this neurologic reaction cause the patient to feel compelled to walk or pace the floor. When sitting he constantly shifts his legs or taps his feet and complains of feeling jittery or anxious. When standing the patient may continuously rock his body forward, backward, and from side to side, or he may constantly shift his weight from one foot to the other. There may be simultaneous chewing movements of the jaw, rolling or smacking of the tongue, and twisting of the fingers.

Most patients are annoyed by akathisia and will not tolerate it long. Relief can be achieved by giving an antiparkinsonian drug orally twice daily; often there is no need to lower the dose of subsequent fluphenazine injections. Sometimes only partial relief can be obtained with moderate doses of an antiparkinsonian drug. Larger doses are inadvisable, however, because antiparkinsonian agents exert psychotropic effects; their coadministration in large doses with depot fluphenazines may precipitate a toxic psychosis. Safer control of severe akathisia can be secured by the simultaneous prescription of moderate doses of an antiparkinsonian agent and small doses of a barbiturate, a sedative phenothiazine such as chlorpromazine, or an antihistamine.

Dyskinesia. Dyskinesia or dystonic reactions are characterized by the abrupt onset of retrocollis, torticollis, facial grimacing and distortions, dysarthria, labored breathing, and involuntary muscle movements. These may be accompanied by scoliosis, lordosis, opisthotonos, tortipelvis, and the characteristic gait of dystonia.

Another form of dyskinesia is oculogyric crisis. The attack begins with a fixed stare that lasts for a few moments. Then the patient's eyes are rotated upward and laterally and fixed in that position. The patient is barely able to move his eyes. At the same time, his head is tilted backward and laterally, his mouth is open wide, his tongue is protruded, and his facial expression suggests pain.

Dystonic reactions can be relieved promptly by the intravenous administration of diazepam or by the intravenous or intramuscular injection of 1 to 2 mg of biperiden or 1 to 2 mg of benztropine mesylate, which may be repeated in a half hour if necessary. Thereafter, oral antiparkinsonian medication should be prescribed every four to six hours for three or four doses. As an alternate therapy, the patient could be given a quick-acting barbiturate, 25 or 50 mg of chlorpromazine given intramuscularly, or an antihistamine. Recovery can also be expedited by having the patient lie down in a quiet, darkened room. After recovery, depot fluphenazine can be continued in lower doses or concomitantly with an antiparkinsonian drug because dystonic reactions are not a contraindication to further therapy with these drugs.

Parkinsonism. Depot-fluphenazine-induced parkinsonism is manifested by varying degrees of intensity and combinations of loss of associated movements, rigidity of limbs, the cogwheel phenomenon, tremors, facial rigidity, poverty of movement, gait and posture disturbances, and drooling. These are usually relieved by adequate doses of an antiparkinsonian agent.

Tardive dyskinesia. It is now well established that any neuroleptic, especially when administered in high doses or continuously for months or years, may cause a neurologic syndrome called persistent or tardive dyskinesia, comprehensive descriptions of which have been written by myself (28) and by Crane (29). When this disorder develops, it continues unmodified or worsens as long as the patient receives the same dose of the causal drug. When medication is discontinued or the dose is reduced substantially, there may be some modification of symptoms, but as a rule symptoms persist for months or years; in most cases they appear to be irreversible.

Persistent dyskinesia has been detected in patients treated with depot fluphenazines; however, each patient had a history of previous treatment for varying lengths of time (usually several years) with different doses of one or more oral neuroleptics (more often the latter) (28). Treatment with a depot fluphenazine alone may cause persistent dyskinesia. However, I believe that the risk of this neurological complication is low. There are several reasons for this. The majority of patients responsive to this form of therapy need relatively low doses initially, substantially lower than if they were treated with the same drug orally. In addition, most patients who are responsive to injectable neuroleptics can often be given progressively lower rather than increasing doses of their medication and still maintain their drug-induced improvement.

Despite these facts, therapists using depot fluphenazines should carefully monitor their patients to avoid this neurologic complication or to lessen the risk of its occurrence. The art of pharmacotherapy with depot fluphenazines includes the administration of the lowest effective dose as infrequently as possible. This means that patients should not routinely receive the same dose at fixed intervals but progressively lower doses at widening intervals.

Convulsions

Convulsions may be sparked by any neuroleptic, espe-

cially in epileptics. They may occur in nonepileptics if large doses are given, particularly in patients with organic brain damage or patients who have had many courses of ECT. However, seizures are a rare side effect of oral and depot fluphenazines. These drugs have been administered to many seizure-free epileptics without provoking convulsions as well as to many partially controlled epileptics without affecting the frequency or severity of their fits.

Examples of seizures induced by long-acting injectable neuroleptics in nonepileptic patients have been cited by Capstick (30) and by Neal and Imlah (31). Capstick described a postlobotomy patient who had a grand mal seizure five months after the first injection of fluphenazine enanthate. Neal and Imlah described a patient who had a seizure two days after the first injection of 25 mg of fluphenazine decanoate, following which the patient became overactive and physically aggressive. Eleven days later this patient was given a second injection of 25 mg of fluphenazine decanoate without adverse consequences.

On the basis of personal experience as well as information from colleagues with extensive experience with potent neuroleptics, I believe that the precipitation of a convulsion by any of these drugs (oral or long-acting injectable) is not an absolute contraindication to further treatment with the neuroleptic. In most instances, continued neuroleptic therapy does not cause a recurrence of convulsions.

Depressive Reactions

Benassi and associates (32) reported depressive symptoms occurring in patients receiving fluphenazine enanthate in 1966. A year later Lambert and associates (33) also called attention to this phenomenon. It was not until 1969, however, when Alarcon and Carney (34) published their report on severe depressive mood changes in patients treated with either the enanthate or the decanoate, that affective reactions during treatment with depot neuroleptics began to receive widespread recognition (35–40). There is now general agreement that mild to severe depressions that may lead to suicide may happen during treatment with any depot neuroleptic, just as they may occur during treatment with any oral neuroleptic. These depressive mood changes may transpire at any time during depot neuroleptic therapy. Some clinicians have noted depressions shortly after the initiation of treatment; others have observed this months or years after treatment was started.

The melancholia that may occur during depot neuroleptic therapy is most often an affective manifestation of an extrapyramidal reaction. It may be a true endogenous depression, but this is rare. All neuroleptics may produce a syndrome that closely resembles an endogenous depression (early waking, morning retardation, self-reproachfulness, and depressed mood) (41). Quite frequently this affective reaction is associated with akinesia and sometimes with a more complete extrapyramidal syndrome. When this type of affective reaction occurs during depot neuroleptic therapy, it most often appears in the first week after injection, as do the extrapyramidal reactions induced by these compounds. Usually, this type of depression remits spontaneously as the intensity of the extrapyramidal reaction wanes. Its occurrence is not prevented by the prophylactic administration of an antiparkinsonian drug or a tricyclic antidepressant.

When a patient treated with a depot neuroleptic becomes melancholic, it is important to determine if this is a drug-induced affective reaction or a true endogenous depression. This can be done promptly by giving an antiparkinsonian drug intravenously. If the depressive symptoms are drug induced, they subside, often within a half hour after the intravenous administration of the antiparkinsonian medication. If they are not drug induced but manifestations of a true endogenous depression, the antiparkinsonian drug is of no benefit. Depot-neuroleptic-induced depressive symptoms that remit temporarily after the intravenous injection of an antiparkinsonian agent can usually be abolished completely within a week by daily doses of oral antiparkinsonian medication. Thus the recognition and immediate treatment of depot-neuroleptic-induced melancholia is important, not only to minimize patient suffering and the risk of suicide, but also to ensure that the patient will not discontinue treatment because of drug-provoked inhibition, lassitude, and loss of drive.

It is an established clinical fact that acute endogenous melancholia occurs during the course of schizophrenia and other severe psychiatric illnesses. It should not surprise anyone that occasionally this occurs during depot neuroleptic therapy. Experience has taught that depressive symptoms can be treated with either a tricyclic antidepressant or ECT and that the depot neuroleptic therapy can be continued (38). If depot neuroleptic therapy is suspended while the endogenous depression is being treated, it may be restarted after the melancholia has ceased without grave risk of a recurrence.

Malignant Syndrome

Delay and Deniker (42) described a rare and sometimes fatal complication of oral phenothiazine therapy that they named the neuroleptic "malignant" syndrome. This syndrome is characterized by hypertonicity with various dyskinesias, pallor, hyperthermia (101–105 F), and pulmonary congestion. This syndrome has occurred in five patients treated with fluphenazine enanthate, one of whom died (43–45).

Meltzer (46) reported the occurrence of extra-pyramidal and hypothalamic symptoms 24 hours after a subcutaneous injection of 25 mg of fluphenazine enanthate in a 21-year-old woman with acute schizophrenia. She first became mute, immobile, and incontinent. During the next 48 hours, rigidity, hyperpyrexia (103 F), hypertension, tachycardia, and coma occurred. These symptoms subsided after treatment with intravenous benztropine, parenteral fluids, and oxygen. Shortly thereafter, because of severe psychotic behavior, further phenothiazine therapy became necessary. Because 2.5 mg of fluphenazine enanthate was tolerated well, increasing doses were injected every three days until a total dose of 25 mg was given over a two-week period. This produced

clinical improvement with mild extrapyramidal symptoms and no hypothalamic symptoms. Twenty-five mg of fluphenazine enanthate every two weeks produced steady clinical improvement so that the patient was discharged from the hospital after two months. During the next six months, 25 mg of fluphenazine enanthate every two weeks was continued, and the patient showed such marked improvement that she was able to return to college.

Meltzer (47) reported later that this same patient was treated with 25 mg of fluphenazine enanthate every two weeks for a year and a half and then with 12.5 mg every two weeks for six months. She is now receiving 1 mg of oral fluphenazine twice a day. She is still in college, and despite some periods of depression and anxiety, she has never had a further psychotic decompensation. There are no neurologic impairments present.

INTERACTION WITH OTHER DRUGS

The fear that adverse interactions might occur between fluphenazine enanthate or fluphenazine decanoate and any other drugs a patient may require has proved to be groundless. Ten years of experience with the enanthate and 9 years with the decanoate have shown that almost any drug can be prescribed with them with little or no risk of harmful potentiation or of other forms of adverse interaction. Even the potentiation of barbiturates, sedatives, and alcohol by a neuroleptic declines rapidly, so that after a few weeks most people being treated with a neuroleptic can take a barbiturate or a sedative or drink alcohol with minuscule risk of any serious potentiation.

The extensive clinical experience to date with fluphenazine enanthate and fluphenazine decanoate indicates that there is little reason to fear adverse interaction of other drugs with these drugs. Many patients treated with depot fluphenazines have taken regularly or intermittently one or more of the following medicines: psychoactive compounds, including lithium, sedatives, barbiturates, and nonbarbiturate hypnotics; analgesics; antiarthritics; antibiotics; anticoagulants; anticonvulsants; antispasmodics; antituberculosis agents; cardiovascular preparations; central nervous system stimulants; anorexics; oral contraceptives and other hormones; diuretics; hypoglycemics; muscle relaxants; and innumerable over-the-counter remedies.

Over 100 different drugs have been taken along with fluphenazine enanthate or fluphenazine decanoate without untoward interactions. It appears that depot fluphenazines can be combined safely with the majority of drugs physicians commonly prescribe.

COMMENTS AND CONCLUSIONS

One prevalent concern about depot neuroleptics is based on the fact that once the substance is injected it cannot be removed from the body. This is true not only for long-acting injectable neuroleptics but also for oral neuroleptics after a few doses. An oral neuroleptic cannot be removed any more quickly than an equivalent dose of the same substance in injectable form. Clinical experience has shown that serious adverse reactions to depot fluphenazines are no more frequent, and usually less so, than similar reactions to potent oral neuroleptics. Reactions to oral neuroleptics have usually occurred only after multiple doses have been absorbed into the body, have acted on receptor sites, and have resulted in the drug and/or its metabolites being bound to proteins, so that rapid excretion is most unlikely, if not impossible. Pragmatically, this does not differ from what happens when a depot neuroleptic is injected. Consequently, clinicians have no more reason to be concerned about the possible consequences of injecting a depot neuroleptic than they have to be concerned about the consequences of administering oral neuroleptics.

The data on the safety of fluphenazine enanthate and fluphenazine decanoate are convincing and consoling. These drugs are as safe as any potent oral neuroleptic, if not more so. The local tolerance of these preparations is very good. Even after years of use, resorption of successive injections is most satisfactory, without any occurrence of inflammation or local induration.

The safety of depot fluphenazines can never justify their indiscriminate or improper use. There is no substitute for accurate diagnosis preceding treatment or for a knowledge of the correct indications and the pharmacologic and clinical effects of a medicine. Sometimes complications are unavoidable, but the best way to minimize the risk of adverse effects is the proper prescription of a drug and close supervision of the patient.

Some physicians are more skilled than others in the art of pharmacotherapy with long-acting injectable neuroleptics. This accounts for the divergent results and complications reported by different therapists. Many of the unusual successes with these drugs must be credited to the ability of therapists whose persistence in the face of difficulties and willingness to take legitimate risks account for the patient's recovery. It is very easy to apply treatment indiscriminately or to err on the side of over-easy discouragement, attributing therapeutic failures and unpleasant complications to the drugs alone.

It is quite likely that the safety of the depot fluphenazines is in part attributable to the fact that the injectable dose is only a fraction of the oral dose of the same drug. The less of any chemical to which patients are exposed the better. This fact alone is one of the true advantages of depot neuroleptics. Another advantage of these preparations is the reduction in the cost of treatment they make possible. DiMascio (48) stressed,

> This means [fluphenazine enanthate and fluphenazine decanoate] of assuring drug intake averages out—for the relatively standard 1 cc–25 mg bi-weekly injection—to a medication cost of 10¢ per day (and since nursing time is not required for daily drug administration considerable savings result).

To this saving must be added the substantial reduction in the hospital readmission rate and in the duration of in-

patient stay. The economic importance of preventing relapse, desirable as it is, cannot be compared to the benefits to the patient whose relapse is obviated. We cannot overemphasize that each acute exacerbation of schizophrenia leaves the patient with progressively greater deficits and that each relapse increases the problems of rehabilitation.

Despite the many advantages of depot neuroleptic therapy, this mode of treatment is not the treatment of choice for all patients, including some who would seem to be ideal candidates. Some patients discontinue treatment because they dislike receiving injections, others stop because it is too inconvenient to return for regular injections, and others have to have their injections terminated because they develop severe intolerable side effects (chiefly extrapyramidal) or because they deteriorate while receiving the injections. Some of these problems will be overcome as the art of treating patients with depot neuroleptics and the organization of aftercare services are improved. It is crucial that clinicians appreciate the full potential of manipulation of the medication, both of dose administration in one injection and the interval between injections. Grozier's guidelines (49) should help physicians master the art of depot fluphenazine therapy. Marriott and associates (50) described the organization and operation of a special clinic for depot neuroleptic treatment.

Since the comparisons of fluphenazine enanthate with the decanoate indicate that the latter has a somewhat longer duration of action and possibly a somewhat lower propensity to elicit extrapyramidal effects, it could appear unnecessary to have two depot forms of the same neuroleptic. However, it must be stressed that the differences just cited are true only for groups of patients and not necessarily for individual patients. There is a place for each of these esters.

Clinicians who have used the enanthate and the decanoate have learned that for some as yet unknown reason the following comparisons are true: 1) certain patients who have responded well to the enanthate relapse or respond less optimally when switched to equivalent doses of the decanoate, 2) some patients refractory or partially responsive to the enanthate respond much better to the decanoate, 3) some patients refractory or only partially responsive to the decanoate respond much better to the enanthate, 4) most patients respond equally well to either the enanthate or decanoate, and 5) the enanthate can be used more readily to control acute psychotic reactions.

That these clinical facts have not been gathered from controlled clinical trials but from the experience of clinicians does not detract from their validity or importance to the welfare of individual patients. The history of psychopharmacology contains innumerable instances of clinical observations by individual therapists being validated subsequently by well-designed, well-controlled, and well-executed trials. It also contains many examples of the limitations of controlled trials.

That the enanthate and the decanoate are quite similar in their effectiveness for many patients should not mask the truth that for many patients one is unquestionably better than the other and that an undetermined number of patients respond to only the enanthate or the decanoate. For these patients the unavailability of the one to which they are responsive could mean that they may be not only prisoners of psychosis indefinitely but subjected to the potential hazards of exposure to less effective medications. Hence, despite their many similarities, there is at present a need for both the enanthate and the decanoate.

The depot fluphenazines were the first representatives of new drug delivery systems in psychiatric therapy. In 1970 I predicted (51) that more long-acting injectable neuroleptics would be developed and that this form of treatment would be used more extensively. Eleven years ago, not one patient was being treated with a depot neuroleptic. Today, an estimated 400,000 patients have been and are being treated worldwide with one of the seven available depot neuroleptics. Cognizant of these facts, some pharmaceutical companies are making additional depot neuroleptics.

The available data on trends in psychopharmacotherapy suggest that in the future more and more psychiatric patients will be treated with long-acting oral and injectable preparations. This is understandable not only for scientific reasons but also because of the mounting pressure to provide mental health care outside of the hospital in the most expeditious, safe, and economical way possible. An increase in this pressure is an inevitable and inextricable accompaniment of national health insurance, which soon will be a reality in the United States.

National health insurance will automatically increase the workload of health care professionals, the number of whom in the mental health field is not likely to rise substantially. Of necessity, mental health care professionals will resort to pharmacotherapeutic regimens that enable them to care for the largest number of patients in the most convenient, expeditious, and economical way feasible. There is every reason to predict that pharmacotherapy with long-acting oral and injectable drugs will escalate and that the use of short-acting oral compounds will decline proportionately. It is conceivable that by the year 2000, the latter preparations will be prescribed sparingly.

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Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations

BY SALEEM A. SHAH, PH.D.

The author discusses "dangerousness to others" as a ground for involuntary civil commitment of the mentally ill, suggesting that there is often a confounding of legal/public-policy concerns and mental health concerns in issues related to this concept. The questionable nature of the presumption of dangerousness in mental patients and the overprediction of dangerous behavior for this group indicate that such commitment processes may circumvent legal safeguards designed to ensure due process. The author recommends that psychiatrists and other mental health professionals assume greater responsibility for the ways in which their services are used in these proceedings.

CONCERN ABOUT THE ALLEGED dangerousness of an individual is raised in a variety of contexts, e.g., involuntary civil commitment of the mentally ill, sexual psychopathy, confinement and release of persons acquitted of criminal responsibility by reason of insanity, and sentencing and release of "dangerous" offenders. The issues and problems pertaining to dangerousness have been the subject of much discussion. Often, however, these issues might best be viewed in reference to a specific area of psychiatric and legal decision making. This presentation will focus on the use of the concept of dangerousness to others in the involuntary civil commitment of the mentally ill. Commitment criteria phrased in terms of dangerousness to self, grave disablement, or the need for care and treatment will not be addressed.

At present, there are 15 jurisdictions in the United States that authorize commitment *only* if the individual is mentally ill and dangerous to himself and others or is unable to care for his physical needs. Fourteen other states provide for such commitment of the mentally ill person if the individual is dangerous or is in need of care or treatment. Various other jurisdictions require that commitment be necessary to protect the welfare of the individual or the welfare of others; still other states permit involuntary commitment when the individual is in need of care and treatment or in need of hospitalization because of mental illness (1, 2).

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DEFINING DANGEROUSNESS: PUBLIC POLICY AND SOCIOPOLITICAL FACTORS

Since involuntary civil commitment represents an exercise of state power that may deprive an individual of his liberty and may also compel him to undergo psychiatric treatment, it raises public policy and legal questions regarding the circumstances which justify such coercive state action (1). According to a basic principle in common law, restraint of insane persons without the usual legal process is justified when the use of such restraint is limited to situations involving imminent danger to persons or property (2). This inherent power to protect the safety and welfare of the public is referred to as the police power of the state. Thus involuntary civil commitments that are justified by reference to a broad societal interest rather than to protection of the interests of the mentally ill person constitute an exercise of police power. There are various restrictions, including Constitutional provisions, that govern and regulate the proper exercise of this power.

Historically, the sovereign, as father of the country, was also responsible for the care and custody of persons who were incompetent to care for themselves. This parens patriae function may be viewed in its current use as a power that citizens have granted to the state for their personal protection. Even though they are less closely regulated or restricted than police power actions, the benevolent intentions and actions of the state have to conform to a number of Constitutional restrictions, e.g., that such actions are reasonably related to a valid state goal (1).

The initial and fundamental question that must be asked when the state wants to use its power and authority to involuntarily confine an individual is, What potential harms to society or to the individual are sufficiently serious to justify resorting to coercive confinement (3)?

Clearly, this question involves public policy, sociopolitical, and legal considerations. It is *not* in this context a medical, psychiatric, psychological, or mental health question. However, determination of dangerousness is often left to representatives of these professions, who may testify as expert witnesses, as a function of the vague statutory language that typifies civil commitment and related laws and of the failure of courts to make explicit judicial determinations and findings of fact (4, 5). This situation leads to a confounding of public policy and legal issues with psychiatric and mental health concerns (6).

Thus two interacting questions are involved in the issue of dangerousness. The first asks, What kinds of behavior

are sufficiently threatening to society to be officially defined as dangerous? This is fundamentally a public policy question. The second question is, With what degree of certainty can one say that an individual will in the future engage in dangerous behavior and, if so, over what period of time? This question is essentially empirical and poses a most difficult challenge to the predictive and prognostic skills of mental health professionals.

SOME OFFICIAL DEFINITIONS AND CRITERIA

Despite the frequent use of the concept of dangerousness, there are few specific and clear official definitions as to the precise behaviors it encompasses. The vague statutory language referring to "danger to self and others" barely addresses this need. However, even a quick review of some of the relevant case law during recent years, especially that which has developed in the United States Court of Appeals for the District of Columbia, indicates that the courts have tended to move away from their earlier and very global notions of dangerousness and toward narrower definitions.

In the case of *Overholser v. Russell* (7), for example, it was stated that competent evidence that the individual may commit any criminal act was sufficient to indicate the likelihood of dangerousness to the community. In this particular case, the criminal charge for which the individual had received an insanity acquittal was writing a check against insufficient funds. Similarly, in the case of *United States v. Charnizon* (8), a defendant who had been involuntarily confined to a mental hospital following an insanity acquittal (on two counts of false pretenses) was denied release from the hospital because he was judged to be likely to pose a danger to himself or to others "in the sense of writing bad checks."

However, in *Millard v. Cameron* (9), a case involving the District of Columbia sexual psychopath law, the court ruled that the statute required that "dangerous conduct be not merely repulsive or repugnant but must have serious effect on the viewer." Later, in *Millard v. Harris* (10), the court stated that the possible harm from the patient's exhibitionism to "very seclusive, withdrawn, shy, sensitive" women was insufficient in regard to the "limits on the extent to which the law can sweep the streets clear of all possible sources of occasional distress to such women." Similarly, in *Cross v. Harris* (11), the court pointed out that "a mere possibility of injury is not enough; the statute requires that harm be *likely*." The court also emphasized that decisions pertaining to the dangerousness of an individual must consider both the likelihood of harm and the magnitude of the anticipated harm.

The quest by the courts for more limited and carefully defined uses of the dangerousness criterion points to the need for mental health professionals to begin to seriously reexamine their uses of this concept and criterion. In the past, there has been a tendency on the part of many physicians and psychiatrists to behave as though there were no particular difficulties in assessing dangerousness. Regrettably, fairly brief, conclusory statements about a patient's mental illness and potential dangerousness—based on equally brief examinations—have often typified involuntary civil commitment proceedings in many jurisdictions (12, 13).

THE CONCEPTUALIZATION OF BEHAVIOR

A major problem in efforts to assess, predict, prevent, and treat dangerous and deviant behavior pertains to the way behavior is conceptualized. Behavior—be it socially defined as dangerous, peaceful, social, or antisocial—is often viewed as stemming largely (if not entirely) from within the individual, i.e., as deriving from his personality. From this perspective, behavior tends to be viewed as a fairly enduring and consistent characteristic of the individual. Moreover, a specific behavioral act may not only be assessed and labeled as dangerous, but the assumption may be made that such samples of behavior are fairly representative of the individual. Hence, through a conceptual shortcut, certain aspects of the individual's behavior are defined as dangerous and then the individual himself comes to be viewed and labeled as dangerous. This, of course, may be misleading and unnecessarily stigmatizing, since violent and dangerous behaviors are often not representative of the individual's typical behavioral repertoire (5).

It is most important that behavior be understood in reference to its social, situational, and environmental context. In other words, behavior should be viewed as involving an interaction between an individual and a particular physical and social environment. This environment may exert major influence on the form, frequency, and range of possible behaviors. Some situational and environmental factors may tend to elicit, facilitate, and even provoke certain behaviors; other factors may tend to have an inhibiting and suppressive effect (14, 15).

WHY THE LINK BETWEEN MENTAL ILLNESS AND DANGEROUSNESS?

The behavioral characteristic of dangerousness often tends to be linked with mental illness not only in reference to civil commitment statutes but also in regard to issues of exculpatory insanity, sexual psychopathy, and even the sentencing of so-called dangerous offenders (16). Typically, an individual cannot be involuntarily confined to a mental institution simply because of his/her anticipated—or even demonstrated—dangerousness. There has to be a finding first of mental disorder and then of an associated propensity or predicted likelihood for engaging in dangerous behavior.

It is somewhat difficult to discern how this link between mental illness and dangerous behavior came about and why it continues to be maintained with such enduring zeal with regard to the entire group of persons officially defined as mentally ill. As noted earlier, to protect the community against dangerous individuals, the state typi-

cally uses its police powers. However, the criminal process is invoked *after* the individual has engaged in some harmful act, i.e., is alleged to have committed a criminal act. The Constitution has generally been interpreted as prohibiting the use of preventive detention against persons who are expected or presumed to be dangerous but have not yet engaged in a criminal act. How far this interpretation carries is illustrated by a case which involved a 39-year-old man who had a criminal history that included successive convictions for manslaughter, shooting with intent to kill, assault with intent to kill, assault with a pistol, assault and robbery, assault and battery, and attempted robbery (17). On the expectation that the man would again resort to a violent crime, steps were taken to involuntarily commit him to a mental institution on the ground of his being potentially dangerous to others.

In upholding a writ of habeas corpus that freed the man from the hospital, the Court of Appeals stated,

> However commendable was the court's purpose to protect the public from the release to society of a man "potentially dangerous to others," there is no District of Columbia statute or inherent equity power permitting commitment to any institution upon that showing alone. Many persons who are released to society upon completing the services of sentences in criminal cases are just as surely potential menaces to society as is this petitioner, having a similar pattern of antisocial behavior, lack of occupational adjustment, and absence of remorse and anxiety; *yet the courts have no legal basis of ordering their continued confinement on mere apprehension of future unlawful acts,* and must await until another crime against society is committed or they are found insane in proper mental health proceedings before confinement may again be ordered. (18, p. 876, emphasis added)

The reader is invited to ponder the implications of this comment. The court ruled that dangerousness alone, without the commission of some new criminal act or a finding of mental illness, was not sufficient ground for the involuntary confinement of an individual with a clear—even blatant—history of violent and dangerous acts. If, on the other hand, a finding of mental illness had been forthcoming, indeterminate and involuntary hospitalization could have been effected. It would appear, therefore, that (at least in part) the linking of dangerousness with mental illness enabled society to utilize preventive detention against certain groups of individuals, a practice which would otherwise run afoul of the Constitution.

HOW DANGEROUS ARE THE MENTALLY ILL?

As Nunnally (19) found several years ago, there are fairly stereotyped public impressions of the mentally ill as "relatively dangerous, dirty, unpredictable, and worthless." Mental patients appear to have taken the place of lepers as the targets of public dislike and rejection (20).

Mental health professionals, particularly those who testify in courts as expert witnesses, have a clear obligation to inform themselves, the courts, and lawyers, as well as the general public, on the extent to which the behavioral characteristic of dangerousness is associated with mental illness. There have been several studies on this subject that have examined arrest records of patients released from mental institutions. These studies, although not free from methodological problems, do not support the public stereotype of the mentally ill as highly dangerous and unpredictable.

Several of the earlier studies found that discharged mental patients had lower arrest rates than the general population (21–23). More recent studies, however, have tempered this picture somewhat. For example, Rappeport and Lassen (24, 25) found higher rates of arrest for robbery and rape among male ex-patients and for aggravated assault among female ex-patients than among the general population. Their studies also found that patients with alcohol problems were most heavily represented in both pre- and posthospitalization arrests.

Giovannoni and Gurel (26) obtained results that were rather similar to those of Rappeport and Lassen in a follow-up of 1,142 Veteran's Administration patients, all of whom were functionally psychotic men. These investigators used several indices of "socially disruptive behavior" (namely, time spent in jail or other penal detention, arrests by police, and all instances of socially disruptive behavior, including criminal activity that may not have come to the attention of the police). They found that arrest and detention rates for patients were higher for certain crimes against persons but lower for crimes against property than among the general population.

Alcohol abuse was a serious problem among these VA patients, 65.8 percent of whom had had some type of alcohol-related problem. Of these, 20.6 percent had an arrest only for drunkenness and 45.2 percent had an offense other than drunkenness and were rated as having trouble with alcohol. It is important to note that alcoholism was not the primary diagnosis for any of these patients; they had all been admitted into the study as functionally psychotic, with 95 percent diagnosed as schizophrenic.

It would seem likely, therefore, that ex-mental patients (i.e., those who have been hospitalized) are not necessarily less dangerous, as a group, then the general population. However, it also seems necessary to consider factors such as the high prevalence of alcohol problems and the probability that psychotic patients would be more likely than other offenders to attract attention to their behavior. Moreover, as Giovannoni and Gurel (26) pointed out, it is quite likely that arrest rates among released hospital patients differ considerably as a function of differing admission, retention, and discharge policies and practices of various jurisdictions and mental hospitals. They pointed out that "none of the data cited [in our study] would suggest any accuracy in the distorted view of the average mental patient as an unusually and predominantly dangerous person."

Thus even though persons diagnosed as suffering from serious mental illness (i.e., those likely to be hospitalized) may not be any less dangerous than persons not so diagnosed, the available evidence points strongly to the conclusion that the mentally ill do not constitute one of the most dangerous groups in our society. Indeed, compared

to groups of criminal offenders, ex-felons, or even persons convicted of drunken driving, it seems very probable that the mentally ill would not constitute the most dangerous group.

PREDICTION OF DANGEROUS BEHAVIOR

Given the numerous court proceedings in which the dangerousness of a mentally ill person is at issue and the very serious decisions affecting life and liberty that must be made, one might assume that some reasonably accurate means of predicting dangerous behavior are available. This assumption would be false. No instrument has yet been developed that can predict violent and other dangerous behavior in a reasonably accurate and satisfactory manner. Indeed, as Megargee (27) noted, no psychological test has been developed that can adequately identify such behavior retrospectively—let alone predict it.

Despite the absence of an adequate prediction instrument, one might still assume that psychiatrists and other mental health professionals who typically make assessments and predictions of dangerousness would have some demonstrated skills in this regard. Once again, the assumption would be false. The available studies indicate quite clearly and consistently that psychiatrists and other professionals overpredict dangerousness to an extraordinary degree. In other words, the overwhelming majority of mentally ill persons who are committed to mental institutions or are denied release from such facilities because of their presumed dangerousness do not engage in dangerous behavior following release (4, 28–31).

It should, however, come as no surprise that very high rates of error are often associated with efforts to predict infrequent events (i.e., events with very low base rates). Nearly two decades ago, Rosen (32) explained on statistical grounds why attempts to predict behaviors with low base rates are invariably associated with very high rates of false positives (in this case, persons who are identified as likely to be dangerous but who in fact do not display such behaviors). Using suicide among psychiatric inpatients as his example, Rosen demonstrated that there would be between 50 and 99 false positives for every 1 correct prediction.

Moreover, given the particular kinds of social and political consequences that attend the two types of error possible in predictions of an individual's dangerous behavior, it is quite understandable that the error to be avoided is the one which would incur undesirable publicity when a released mental patient later displayed violent behavior in the community. Thus the number of false positives would tend to be further increased in efforts to avoid such societal responses.

Psychiatrists and other mental health professionals are thus presented with some very perplexing decisional problems as well as related public policy questions in the assessment and prediction of dangerousness. These basically difficult problems become more complicated when differing—or conflicting—decision rules enter the picture (6, 33). For example, in the criminal process, rather elaborate safeguards have been instituted to ensure due process for the accused. In addition, in criminal trials a decision rule is used that requires proof of guilt beyond a reasonable doubt—to ensure that any error will be consistent with the values of our society, i.e., will result in erroneous acquittals—not erroneous convictions. Medical decision rules, which obviously are concerned with very different types of consequences, appear to be quite different. The cautious physician operates on the rule "When in doubt, suspect illness." Certainly, the social values and consequences to be avoided are quite different from those in criminal trials.

However, in view of the fact that involuntary civil commitment of the mentally ill pertains, fundamentally, to public policy and legal questions and involves the state in coercive intervention in the lives of individuals, legal rather than medical decision rules would seem to be clearly indicated. Stated differently, when the individual faces involuntary confinement in a situation that involves legal and judicial decisions, as contrasted with the typical physician-patient relationship, mental health professionals need to be very cautious about their decisions. There are already rather clear indications that the relatively weaker decision rules of various civil proceedings (e.g., preponderance of the evidence) are moving toward stricter burden of proof requirements (34–36).

SOME PUBLIC POLICY IMPLICATIONS

Issues of dangerousness and the involuntary commitment of the mentally ill exemplify rather strikingly the manner in which public policy and legal questions have been translated into psychiatric and mental health terms. Stated differently, what would appear essentially to be issues relevant to the state's use of its police powers seem to have been rephrased and shifted to the exercise of parens patriae functions. It is almost as though the recitation and announcement of benevolent societal intentions is necessary for the justification (rationalization?) of practices that suggest social control rather than therapeutic concerns.

By blurring and obscuring the fundamentally moral and public policy issues intrinsically imbedded in the balancing of competing societal interests and values and turning them into mental health questions, it has been possible to justify societal practices that infringe grievously upon the rights and liberties of the mentally ill.

It is not surprising, therefore, that some of the most predictably and demonstrably dangerous persons are *not* preventively detained (as in the case discussed earlier) or handled with greater concern for public safety. For example, numerous studies have provided rather consistent evidence that about 50 percent of all fatal accidents involve drunken drivers. It also appears that less than 10 percent of the driving population (namely, those with serious drinking problems) account for almost two-thirds of all alcohol-related traffic fatalities (37, 38). However, our society demonstrates a truly astonishing tolerance for

this group of demonstrably dangerous persons. It is likely that more persons are killed and seriously injured by drunken drivers during the course of a single week than by all combined categories of psychotic individuals over an entire year—perhaps even several years.

In view of the very vague definitions of "dangerousness," the very low predictive accuracy and the glaring overpredictions of such behavior, and the involuntary and indeterminate loss of liberty that follows civil commitments, the labeling of the mentally ill as dangerous could in itself be regarded as a rather dangerous activity. One might well wonder whether, in the various civil and parens patriae proceedings in which psychiatric concepts are invoked and mental health professionals are involved, the societal practices seem to be more concerned with using these professionals as agents of social control rather than as individuals functioning in their usual and traditional therapeutic roles (29). In the final analysis, we must assume greater responsibility for the ways in which our services are used—or misused.

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Milieu Process During the Residency Turnover: The Human Cost of Psychiatric Education

BY KENT RAVENSCROFT, JR., M.D.

The author describes the stresses inevitably brought about by the turnover of large numbers of psychiatric residents in ward communities involved in milieu therapy. He presents recommendations to ease the stress felt by patients, staff, and trainees during the three phases of the turnover process—anticipatory, acute reactive, and reintegrative. Basic to the working through of these stressful periods is an understanding of the turnover process and the availability of experienced staff for support and guidance.

IN PSYCHIATRIC HOSPITALS involved in staff and residency training, the end of the training period and the resulting turnover of personnel inevitably set certain milieu processes in motion (1–5). While necessary for training purposes, this institutionalized turnover, which involves a significant number of staff, has its human costs for patients and permanent staff alike, since they must continue the hard work of treatment while dealing with important losses and adjusting to new trainees.

The most significant turnover in teaching hospitals involves the first-year residents and chief residents (6–8). This residency turnover always sparks powerful interrelated milieu processes involving everyone on the ward—nursing staff, residents, social workers, and patients (9). Observed longitudinally, these milieu processes reveal a complex and dynamic set of group processes with a natural pace and sequence. Although residencies and psychiatric ward structures vary from hospital to hospital, certain major dimensions of the turnover process are sufficiently recurrent and universal to permit general description and conceptualization.

For analytic purposes, the process of residency turnover can be divided into the three following phases: 1) the anticipatory phase, which begins about three months before the actual turnover; 2) the acute reactive phase, which occurs around and about the actual turnover and lasts only a few weeks; and 3) the reintegrative phase, which follows the turnover and involves working through the difficulties and readjusting during the following three months.

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SETTING AND METHOD

This research was carried out on a 50-bed inpatient ward at the Massachusetts Mental Health Center (10–12). In order to have access to the multiple groups of the ward milieu, I became a nonparticipant observer, sitting in on or tape-recording all of the formal and many of the informal staff, resident, and patient meetings over the course of a clinical inpatient year. The data gathered in this study are presented in an annotated narrative form.

THE ANTICIPATORY PHASE

About 10 to 12 weeks before July, as the turnover approaches and the departure of first-year residents and the chief resident becomes imminent, the permanent staff, who know how things go on the ward, begin slowly to turn some of their attention and energy away from the patients and the treatment process. They begin to face the impending loss of the first-year residents, who will be relocating themselves in offices off the ward and assuming other duties in addition to treating their remaining inpatients.

The permanent staff are thus faced with both the affective task of grieving the departing residents and the practical task of temporarily assuming an increasing share of the psychiatric management of patients. The residents are progressively deinvesting themselves of ward life and preparing for their new outpatient responsibilities elsewhere.

Because the head nurse knows what is coming, she often sits down with the departing chief resident and urges him to review which patients have overstayed their time on the ward, often for teaching purposes, and which patients could possibly be pushed enough to be ready for discharge before the first-year residents depart. When the residents, and sometimes the patients, get wind of these high-level decisions generated by turnover pressure (i.e., because of ward calendar and system needs), they begin to react, and the effects ripple down through the ward.

Since patients have the least amount of power in the

system and are the least aware of the implications of the impending turnover, they are left with an ill-defined and disconcerting sense that something is shifting in their relationship with the staff. They are subtly but progressively left more on their own or even pushed toward "progress," apparently because their nurses and doctors expect or somehow need it.

Well before the residents actually depart, they and the nursing staff begin to make formal and informal preparations for the turnover. The depth of the bonds between nursing staff and residents is often profound because of the unique pressures and responsibilities on the ward and the nature of the teaching and learning experience. Although it is never fully acknowledged, the nurses and attendants have had a major influence on the personal and professional development of the first-year residents as well as the chief resident. As the time approaches for the change, prominent swings can be observed between idealized friendliness and nostalgic reminiscences on the one hand and frustration, alienation, and recrimination on the other. Near the turnover date, the residents take part in a ritualized rite of passage by making formal retrospective presentations during staff meetings, which become noticeably diverted from their usual patient focus.

In spite of their attempts to maintain clinical work, the residents and staff turn progressively into themselves as they invest the separation process and begin to work through the parting. During this period, the nursing staff as a group, like the residents, draw affectively more into themselves, turning to each other for the support available only from their own in-group. They swing ambivalently between praising and criticizing the departing chief and first-year residents, who are, in a sense, their unacknowledged professional offspring. Put another way, the residents are their most ideal patients and most successful ward milieu products.

Ironically and yet understandably, it is at about this time that nurses begin to talk privately about lousy pay, long hours, poor privileges, and greener pastures elsewhere. Later, talk of quitting begins and a strikingly increased pattern of sick leave emerges among the nursing and attendant staff. Although the prevalence of actual resignations is low all year, a higher incidence clearly clusters around the time of turnover. The staff is under mounting stress during this period: they experience the double burden of losing the group of old first-year residents and chief resident and then breaking in the new crew.

The oldtimers on the staff seem to schedule their vacations for this period; they have found a way to survive the stressful period by avoidance through planning and seniority. Newcomers to the permanent staff, who often last only a year or two, sometimes quit at this time, not having established a regular vacation schedule. The actual peak for staff sickness and resignations, however, occurs during the reintegrative phase.

It is only during the last week or so before the turnover occurs that speculation about the incoming residents begins in earnest, taking on suddenly the proportions of messianic hope with an undercurrent of apprehension and foreboding. Meanwhile, the patients, revolving around this spectacle (which has upstaged treatment to a fair degree), are thrown into group disarray and confusion. They do not quite know what is happening on the ward, let alone what to expect next. Community ward meetings, which in general serve to clarify ward and administrative reality and to work through relevant community issues, always take up turnover-related topics and troubles, and the focus is usually on the erratic and problematic behavior of the patients. This patient behavior is repeatedly attributed to their group and individual pathology; the impact of object loss during turnover on the patients collectively and individually is only partially recognized.

What is usually conspicuously missing from these meetings is an honest acknowledgment of the erratic and problematic behavior of the staff during this period, which necessitates major coping maneuvers on the part of the patients, who have variable resources and limited social awareness. In essence, because of the overdetermined and conflictual staff pressures and problems during the turnover, there is a recurrent and observable tendency on the part of the staff to lose their objectivity, overlook their own emotional and behavioral contributions to patient behavior, and displace their problems onto the patients. By externalizing these issues, the staff disown their contributions to and compound the burden of the patients; the staff also work on their own problems by means of this process of temporary displacement onto the patients.

During this period, it is manifestly difficult for the staff to help the patients deal with issues that are so consuming and so difficult for the staff themselves to deal with. Only later, when the staff are progressively able to recognize their own problems, take responsibility for them, and work them through themselves, does this process of displacement lessen in the community ward meetings, permitting the staff to help the patients settle down and work through their turnover-related problems.

THE ACUTE REACTIVE PHASE

After the actual turnover occurs, most of the patients still belong to the now departed residents, who have entered their second year. Admissions come slowly to the new first-year residents. The permanent staff begins to miss the second-year residents, who are suddenly absent from all ward meetings and are seldom seen except for periodic, momentary visits and informal stops by the nursing station. The nurses become angry and impatient because the second-year residents are so hard to contact for the practical business of patient management—let alone for emotional and intellectual support.

The permanent staff members are faced with increased responsibility for managing inpatients whose doctors are virtually absent. This burden is only partly eased by the incoming chief resident, who is new to his job, and by the visit of the staff psychiatric consultant, who is more removed from the ward. During this period, therefore, anx-

iety and tension are high, not only on each ward but throughout the hospital.

Until the nurses and second-year residents reestablish a satisfactory system of communication and emotional exchange, the nursing staff must assume, with the new chief resident, what amounts to a tacit or covert therapeutic-administrative split. The second-year residents continue individual therapy while leaving much of the minor and some of the major administrative decision making to the nursing staff. In a functional sense, during this period a great deal of role blurring is evident. Because of the increase in physical, social, and emotional distance between residents and patients and between residents and staff, acute signs of disorganization appear.

The nursing staff are also assuming their greatest teaching challenge of the year in the new first-year residents, who are relatively inexperienced in psychiatric management. While the new residents are given a great deal of authority, the nursing staff see themselves as having to take more of the administration and teaching into their own hands at first—a situation requiring a great deal of tact and skill.

Although the new residents are generally bright, competent, fast to learn, and fairly aware of their lack of specific psychiatric knowledge and clinical judgment, their sense of self-esteem and adequacy is at stake. They are therefore understandably anxious and defensive. This colors their perceptions and interferes with their readiness to seek staff advice. In addition, their medical ward mind-set is to see nurses, social workers, and attendants as below them. The residents are therefore prone to make errors in clinical judgment. They have difficulty collaborating with and learning from the staff, especially nurses and attendants who know the patients best (10–12). Conflicts inevitably develop, and much emotional and practical work is consumed within the staff, withdrawing time and emotional energy from investment in patients.

The patients themselves suddenly discover that their doctors have virtually disappeared from routine ward life and an invasion of new, inexperienced doctors has occurred. At the same time that they are experiencing the partial loss of the accustomed proximity and availability of their own doctors, they are subjected to adjustment to a new chief resident, who runs their ward meetings and makes management decisions. They are also required to accept closeness to strange new residents in their ward life. Because the nurses and attendants, who are usually closest to the patients, are preoccupied with loss, change, new administration, and increased teaching, they are less available for intimacy and support.

Under these circumstances, individual psychotherapy, which is now conducted off the ward in a strange new office, tends to become a retreat from the ward confusion. Patients find themselves working with second-year residents who are also going through similar major emotional adjustments to leaving the ward. The residents are assuming challenging new responsibilities in the emergency walk-in clinic and outpatient department. Since the residents are struggling for a new staff relationship, their receptivity to patient difficulties with the nursing staff of the ward they left is reduced because this is an acute conflict area for the residents. Although empathy may eventually be the result of shared experiences in the turnover process, defensiveness and unavailability are often major obstacles to therapy during the acute reactive phase.

Thus patients experience a great deal of stress individually and collectively because their doctors are less available and the ward staff is more preoccupied. In general, since patients have the least status and power in the ward system and are the most inexperienced in ward policy and process, they find themselves at a serious social disadvantage. They lack orienting information on what is happening around them; it is as if an unwritten social treatment contract were being unilaterally altered or broken (13). As a result, individual and group disintegration slowly develops.

Patients' emotional needs are great, their coping reserves are low, and their patterns of reaction are more characteristically pathological. Depending on the ward population, certain patients ("barometer patients") begin to react to the mounting turnover stress. Some become anxious, angry, and active; others become depressed, dependent, or distant. Some patients begin to manipulate or act out, contagion can occur, and the incidence of angry confrontations, escapes, and suicidal gestures may increase (14–17).

During this period, staff are less available to receive affects, especially anger and depression, and are less able to give structure and support (18). As their feeling of abandonment mounts, some patients become demanding of both staff and other patients. The staff's definition of what is demanding changes, their tolerance for intense dependency needs and difficult challenges diminishes, and their capacity and patience for anger and acting out decrease. As things get tighter and tighter on the ward and trust and communication decrease between individuals and between groups, the ward can get high, low, or very tense. Incidents with individuals or groups can occur. This is the picture of the turnover in the acute reactive phase.

THE REINTEGRATIVE PHASE

No sharp lines can be drawn as to when the acute reactive phase blends into the reintegrative phase; regressive and progressive movements develop in individuals and groups. The subsequent process of reintegration and working through has antecedents in both previous phases of the turnover process, yet it gathers momentum now. This involves an interplay among all ward groups and follows a natural sequence.

Since the turnover creates distance and difficulties between second-year residents and the nursing staff, they become angry and rebellious with each other or sad and withdrawn. Splitting of affect and attitude between the nursing staff and the second-year residents can occur: nurses can idealize some residents and scapegoat others or idealize all of the second-year residents and denigrate all of the first-year residents. Second-year residents, for

their part, can go through the same process of splitting with the nurses.

Although these trends rarely occur in a pure form, they do occur and represent shared reactions of either an idealized or paranoid variety. This permits initial intragroup cohesion and eventual reintegration. Such trends may result in various transient pathological side effects for those targeted or outside of the momentary "love-ins" or "hate-ins," even though the establishment of in-groups represents the beginnings of ward group reconstitution and milieu healing. Later, as feelings become tolerable, ambivalence becomes manageable, and attitudes become reasonable, intergroup cohesion emerges, and the milieu reintegrates.

For example, individual and group conflicts can emerge between staff and all residents to some degree, and with certain residents to an even greater degree, depending on how smoothly these residents and staff work through their adjustment. If resolution is blocked, patients can be caught in a crossfire between remote second-year residents and permanent staff members that goes beyond the average therapist-administrator split.

In some instances this can lead to the phenomena described by Stanton and Schwartz (19), who hypothesized that pathological excitement of psychiatric patients is often associated with hidden staff disagreement about patient treatment and management. The patient gets caught in a crossfire of confusing staff messages and reactions, resulting in heightened conflict and tension within the patient, who eventually becomes excited or even acts out the hidden staff conflict. These phenomena are, in a sense, built into the social system of ward structure and derived from the turnover pressure itself.

In other words, to the degree that these conflicts remain intense, covert, and unresolved among staff, especially while the administrative situation remains loose and unintegrated, the patients may act out staff conflicts. Some patients can make use of the unresolved conflicts and poor communication to actively manipulate staff members during these periods.

The pressures of this phase of the turnover process can result in group phenomena on the ward, including ward highs and lows and an increase in acting out, escapes, and even suicides (20, 21). Group contagion, based on high levels of stress within the entire ward, underlies these eruptive epidemic phenomena, which appear in clusters during the turnover. Such staff behaviors as increased sick leave, personal and group conflicts, and resignations reflect the turnover pressure; they are staff counterparts to turnover-related patient morbidity and mortality.

Staff members with high status or more seniority take annual leave during both the acute reactive and the reintegrative phase, thus avoiding some of the pressure for themselves but clearly increasing it for the remaining staff and patients. Traditionally, the psychiatric administrative and supervisory staff also take off during this period—usually for the entire month of July or August. This leaves only a skeleton crew for ward coverage. (The choice of words here is intentional, for the first-year residents are perhaps most in need of support, and the second-year residents only somewhat less so; the group exodus of medical supervisory support places an additional burden on the residents.) The stress gets transmitted to the patients and nurses through the first- and second-year residents, setting up a vicious circle.

The feeling of abandonment by staff and residents is eventually verbalized by the patients in ward meetings, after initially appearing within patient groups serving as in-group enclaves for comfort and complaint. The sense of deprivation often leads to an anxious, dependent, or depressive patient stance in individual therapy and ward meetings. Eventually this turns into an angry, defiant, and challenging posture.

Open confrontation about staff unfairness or neglect erupts at times at ward meetings, often over seemingly trivial issues. This eruption takes the staff by surprise with its intensity and apparent inappropriateness. Of course, no matter how myopically the staff perceive and interpret the situation, it is a cumulative one, highly overdetermined and very real and important to the patients.

Telltale antecedents to patient contagion and confrontation are the initial depressive stance and complaints about dirty conditions, poor food, lousy rules. When these complaints heard in patient cliques and ward groups give way to more collective and outwardly focused anger toward staff about unfairness and neglect, individual and collective action is not far away. Passive depression shifts to hostile dependency and then to collective feelings of impatience and anger with the absent doctors and withdrawn staff. This patient reaction of self-assertion, in a real sense, contributes to curing the ward of its turnover syndrome, provided that it is recognized as potentially healthy patient initiative and is eventually faced and harnessed constructively by the staff.

Initially, however, the nurses are tired, overworked, and depressed. They begin to gripe to each other and at each other in their private groups and informally around the ward. They complain about salaries, the number of days off, the amount of work, the second-year residents, the departed chief resident, and the troublesome, incompetent new residents.

The new residents are described as "bulls in a china shop" or as "too lazy and passive." As the nurses get themselves together they begin to make more open complaints and invidious comparisons between the new and the old residents—remarks that are cryptically interspersed among tactful supportive and educational efforts. These remarks are usually made first to the head nurse, then more directly to the residents and their chief. A similar cycle of depression and then aggression can be seen among the attendants.

A major staff-patient confrontation in a ward meeting or other serious incident usually shocks the staff out of their withdrawn state and interrupts the staff-resident infighting and polarization—uniting them and refocusing their attention on the patients and the treatment work to be done. There is customarily an overreaction out of guilt and concern for the patients and a tightening of restrictions. The staff attempt to understand what is going on. This is translated into careful, conservative, and tight ad-

ministration with compulsive individual and group attention.

Barring such serious and disruptive events—especially if the prodromal signs and symptoms of a turnover crisis are recognized early enough and intervention and management are undertaken—the period of working through usually continues at a more leisurely pace. The nurses finally stop griping at each other and in private about the patients and residents. About two months after the turnover the nurses feel the residents have had enough of a honeymoon in terms of teaching and support. They feel the residents should come of age and start giving and being more independent and active about management and staff relations.

Eventually, the head nurse confronts certain residents at a staff meeting with their lack of assertion and poor communication. This is usually done first individually with the second-year residents. After mutual resolution with this group, it occurs with the first-year residents. The first-year residents then complain that the nurses have not been carrying out their orders well and do not tell them enough about their patients.

With such individuating encounters, lines of authority and responsibility are redrawn, rank is pulled, and the level of trust and intimacy becomes sufficiently high to permit more open mutual assertion and criticism. The nurses begin to relinquish more and more of their temporarily increased management, teaching, and support functions, and the residents give up their dependency and defensiveness as their individual and collective competence and professional identity are consolidated.

After a series of such reciprocal encounters, which usually take place about two to three months into the residency, the residents noticeably begin to take more initiative. Collaboration becomes the rule rather than the exception. As staff relationships progressively normalize, the nurses, residents, and attendants become increasingly relaxed and available to the patients. Reciprocally, the patients feel themselves to be under less stress. Finally, the major work of treatment progressively takes center stage once again after this annually recurring turnover drama resolves. Thus at about the three-month mark the ward has essentially come back into normal equilibrium.

CONCLUSIONS

Psychiatric education is obviously critically important in order to provide continuing excellence of clinical care and research and to supply increasing personpower to meet our country's urgent needs. Moreover, psychiatric training and educational activities in many ways clearly contribute to the overall high level of psychiatric care seen in teaching hospitals. Nevertheless, given the nature of a psychiatric ward system and the processes set in motion by the turnover of psychiatric residents, there is an equally clear human cost to psychiatric education for permanent staff members and patients alike.

In order to set the stage for effective treatment, most psychiatric wards are structured to create deep and intense emotional involvement as well as powerful, task-oriented dependency between and among staff and patients. The residency turnover radically interrupts this clinically created ward process for reasons that are independent of patient treatment needs. Since the turnover process is initiated iatrogenically for training purposes and follows a natural time course, it is incumbent upon the staff in psychiatric hospitals to know the turnover syndrome well, for the sake of their patients and for their own sakes—in order to minimize patient and staff morbidity and, sometimes, mortality.

Kahne (20) documented the higher incidence of patient suicides during the period of highest staff and patient turnover. Although I have stressed the correlation of other less serious but still important forms of patient morbidity, I would also emphasize staff morbidity and mortality. Although no systematic study of staff suicide has come to my attention, my own informal data suggest a small but impressive clustering of staff suicides around the turnover time, including residents, supervisors, training directors, and other administrative staff.

It should also be mentioned that there are other high-risk periods for both staff and patients during the year, as with the population in general. Such religious and secular holidays as the Christmas-Hanukkah-New Year season and the Passover-Easter season create emotional and physical separations between inpatients and staff and represent institutionalized treatment interruptions. The morbidity and mortality that attend these separations are similar to those which occur during the turnover, with the added component of family and cultural stress.

For consultants and staff serving institutions other than psychiatric hospitals, it is crucial to keep in mind that the principles of administration and management discussed here are applicable generally for all institutions, such as schools and general hospitals, in which staff, student, client, or patient turnover and holiday seasons create separations and interruptions of intense relationships.

The first rule of medicine is *primum non nocere*, first of all do no harm. As Santayana observed, "Those who cannot remember the past are condemned to repeat it." Although the residency turnover cannot be avoided, it is my contention that the more we know about it the better it can be structured, managed, and worked through. Toward this end, I would like to offer the following recommendations, recognizing full well that many other options exist for specific institutions once the nature of the turnover syndrome is clearly understood.

RECOMMENDATIONS

At the institutional and programmatic level, hospital and ward administrators could introduce such preventive policies as the following:

1. Stagger the entry and departure of residents and other trainees during their inpatient rotations.
2. Provide transitional structure and support for permanent staff members and patients by means of a period

of overlap for residents phasing in or phasing out of the ward system.

3. Require new first-year residents to assume responsibility gradually during their phasing-in orientation and observation period.

4. Schedule new chief residents to come three or four weeks ahead of the new resident groups, and have the new chiefs overlap with the old, with an interim period of coadministration of the ward.

5. Insist that permanent senior supervisory and administrative staff of all disciplines (head nurse, team leaders, chief social worker, head attendant, training director, clinical director, superintendent, etc.) not take their vacations during the high-risk period beginning one month before to two months after the turnover, or carefully stagger necessary absences to avoid having a skeleton crew just when the most experienced support and guidance is needed. For respecting this preventive policy and assuming the additional crucial responsibility, senior staff should receive special recognition or incentive pay or compensation (e.g., extra leave days for vacations taken at lower-risk times).

At the ward or clinical level, senior staff could implement the following procedures:

1. Hold educational and experiential group and intergroup workshops before and during the turnover, including staff and trainee groups and interdisciplinary exercises using Tavistock (22) and A.K. Rice Institute (23) methods. These workshops would provide conceptual tools for acknowledging the issues and affects of the turnover, for following the process throughout its course, and for working through the fantasies, feelings, and facts involved.

2. Communicate their stable, enduring presence, as well as their seasoned familiarity with the turnover pressures and problems, directly to the permanent staff and the rotating residents. Experienced senior staff who are normally integrated with the ward or acting specially as consultants during this period should continue their pivotal role throughout the turnover period.

3. Review or teach the prodromal signs of increasing turnover pressure. The more familiar the permanent staff and residents are with the premonitory signs of turnover pressure within themselves and the patients, the more prepared they will be to intervene early and manage it constructively. This could prevent morbidity and sometimes mortality among the patients and among staff members.

4. Make use of regular ward disciplinary and interdisciplinary staff meetings to monitor and supervise the turnover process as it unfolds, clarifying turnover issues and advising staff on clinical administration and therapeutic management within their own groups and with their patients.

5. Supervise frontline staff in formal work with patient groups and in psychotherapy, with an ear for turnover complications in therapeutic work and administrative decisions.

6. Remind staff members to be on the alert for informal patient group formation (24–26) and group processes that often happen while staff are preoccupied with turnover. Support creative intervention and constructive working through focused on spontaneous turnover-related group initiatives. Similar intervention focused on spontaneous turnover-related issues and themes appearing within formal ward groups should be encouraged. This kind of intervention can harness patient awareness and initiative, minimize morbidity, and maximize therapeutic gain from the inevitable turnover experience.

It has become clear over years of milieu observation that while the physical absence of certain staff members, especially large numbers of key members, can be very difficult for patients, the emotional absence of staff members actually present on the ward can be even more devastating. Patients turn, of necessity, to these remaining staff members for support, for venting anger, and for solace, only to find that they, too, are absent. From this observation it becomes clear that during the entire high-risk period of the residency turnover the more available and aware the staff are among themselves as well as with the patients, the better for all concerned. This depends on active, healthy working through of the turnover by the staff under expert support and guidance, so that they may, in turn, do the same with their patients.

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The Selection of a Psychiatric Curriculum for Medical Students: Results of a Survey

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A survey of 131 psychologists, psychiatrists, and nonpsychiatrist physicians taken to determine what doctors of medicine should know about psychiatry revealed that of the 21 topics assessed, there was a significant intergroup agreement on the 10 most important and the 5 least important topics. Interviewing, suicide evaluation, the chronically ill or dying patient, and psychiatric referral received high ratings by each group, and psychoanalytic theory, psychodynamics, and mental retardation received uniformly low ratings. The authors believe that these findings provide useful information for planning an undergraduate curriculum in psychiatry.

IN RECENT YEARS many papers have been published pertaining to psychiatric curricula as taught in medical schools (1–5). Most of these have been concerned with the development of innovative teaching methods or single, specialized courses. Few studies have dealt with the problems encountered in the attempt to define and select an entire curriculum. In this paper we will examine current recommendations about psychiatric course work and propose a curriculum based on a consensus of 131 physicians and mental health professionals.

CURRICULUM SELECTION

Most medical educators agree that medical students should learn something about the discipline of psychiatry and the application of its principles to patient care. It is reasonable to assume that there is a core of psychiatric knowledge and skills about which all medical students should be taught. However, up to the present time no consensus has been reached about what the composition of this core curriculum should be. Furthermore, limitations in time and faculty often dictate that only the most relevant material be taught, but frequently it is difficult to separate psychiatric information that is essential for students to learn from that which is useful and interesting. The choice of appropriate topics may be complicated further by the presence of departmental or theoretical biases. It is likely that course selection would be facilitated if a more objectively derived and generally agreed-upon curriculum guide were available.

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The Literature

There is evidence which suggests that psychiatric educators have thus far not succeeded in selecting relevant curricula for their students. In an evaluation of undergraduate psychiatric education, Castelnuovo-Tedesco (6) surveyed recent graduates from a cross-section of American and Canadian medical schools to determine their attitudes toward their psychiatric training. Forty-nine percent of the 110 respondents felt that the course content did not adequately prepare them to deal with psychological problems encountered in medical practice. These findings led Castelnuovo-Tedesco to conclude, "Further evaluation of the results of teaching and closer scrutiny of the curricula (with emphasis on what the student finds useful) appear in order." The results of this study imply that modifications in psychiatric curricula and review of psychiatric course material are needed.

A review of published curricula representative of various psychiatric educators offers insight into some of the dissatisfactions expressed with psychiatric teaching. In one of the few published attempts to achieve a consensus about the composition of a core curriculum, the American Psychiatric Association (7) conducted a survey of 48 psychiatric departmental chairmen. The chairmen were asked to state their opinions about what essential subjects should be covered during the psychiatric education of medical students. The most frequently mentioned topics included community psychiatry, interviewing skills, the doctor-patient relationship, psychology, psychopharmacology, genetics, and drug abuse. Zolik and Miller (8), Fink and Hicks (9), Pritchard (10), and Romano (11–13) are representative of individual educators who have made specific proposals. Fink and Hicks emphasized the importance of teaching sociology, anthropology, psychodynamics, and interviewing techniques to medical students. Pritchard gave a high priority to teaching about human development; disturbances of memory, cognition, and perception; and the doctor-patient relationship. Zolik and Miller recommended that a wide range of subjects be taught, including such topics as principles of psychosomatic medicine, psychiatric diagnosis, and psychoanalytic theory.

Limitations

These proposals, singly or in combination, are limited as a guide for other educators. The various curricula appear relevant and interesting when each is considered separately. Viewed collectively, however, they show a considerable diversity in subject material. It is improbable that many medical schools have the faculty or time to instruct effectively in all, or even most, of the topics listed. Thus the task still remains to select the most pertinent subjects from many worthwhile ones.

Perhaps the most serious deficiency of the proposed curricula is the lack of any "in the field" appraisal of their clinical applicability and relevance. Aside from Castelnuovo-Tedesco's survey (6), there has been little or no meaningful evaluation of the usefulness of psychiatric instruction from the perspective of the consumer, i.e., the nonpsychiatrist physician. Curricula designed by even the most experienced psychiatrists or psychiatric educators may not be attuned to the actual needs of their nonpsychiatrist colleagues. Unless the psychiatric knowledge and skills acquired are usable and are felt to be of value by the practicing physician, they soon will be forgotten. The usefulness of a psychiatric course is ultimately best judged by the practitioners who apply it clinically, and their evaluations about course content should be taken into consideration when planning a curriculum.

Another point deserving comment is that none of the recommended curricula have been ranked according to their relative importance. This may lead the reader to believe that the topic listed last is as necessary to teach as the one listed first. It is a distinct advantage for the educator to be able to discriminate readily between teaching topics that have a greater or lesser relevance. If a hierarchy of subject importance were available, it would greatly facilitate the curriculum selection process. Course material especially pertinent for the student could be expanded or contracted according to its assigned priority and the time available.

METHOD

We at the University of Southern California School of Medicine felt that a more satisfactory core curriculum could be defined if it met the following criteria: 1) it would be derived by consensus of many health care professionals rather than individual or even small groups of psychiatrists, 2) it would contain a hierarchical rank of topic importance, and 3) it would include judgments by practicing physicians about the usefulness of psychiatric subject material. In order to accomplish these goals, a survey was developed to assess the opinions of a cross-section of mental health professionals, medical educators, and practicing physicians. They were asked to complete a questionnaire that posed the question, "What specific psychiatric information and skills should a nonpsychiatrist physician have?" It was hypothesized that a list of the most essential teaching topics could be derived from the data obtained, and from these topics a core curriculum could be constructed.

The questionnaire was designed to provide the following data: 1) an overview of current opinion regarding the contents of a psychiatric curriculum, 2) a consensus (in contrast to the opinions of individuals) about topics that should be included in a psychiatric curriculum, 3) a ranking of psychiatric subjects according to their relative importance, 4) impressions from nonpsychiatrist physicians about the psychiatric skills and information that they believe are important to know, and 5) a comparison of the curriculum topics proposed by psychologists, psychiatrists, and nonpsychiatrist physicians.

The respondents were requested to identify themselves as being a psychologist, psychiatrist, or nonpsychiatrist physician. They were then asked to evaluate 21 psychiatric subjects commonly taught to medical students. The subjects were chosen from those suggested in the literature and from courses previously offered by our department at the University of Southern California School of Medicine. Each of the topics encompassed a general area of psychiatry and was stated in a brief but descriptive fashion. Spaces were provided for the respondents to add and rate topics of their own if they so desired.

The respondents were asked to rate the relative importance of the topics by assigning one of the following designations to each: 1) not at all important, 2) moderately important, 3) very important, and 4) essential. The forms were completed and returned anonymously.

A concerted effort was made to obtain opinions from a representative cross-section of professional disciplines and individuals. A total of 150 questionnaires were sent to faculty members at the University of Southern California School of Medicine, the school's Department of Psychiatry and Division of Psychology, and to the staff of two local psychiatric hospitals. In addition, 35 questionnaires were completed by the staff members of a private general hospital. Approximately two-thirds of the nonpsychiatrist physicians surveyed were pediatricians, internists, and family physicians. The remainder practiced various surgical specialties. All but two of the nonpsychiatrist respondents were regularly involved in providing direct or indirect patient care. Approximately two-thirds of the group participated in the education of medical students and/or residents. One-third of the total number of respondents were in full-time private practice. The psychologists and psychiatrists surveyed represented a wide variety of theoretical orientations.

RESULTS

We received completed questionnaires from 18 clinical psychologists (all had Ph.D. degrees), 48 psychiatrists, and 65 nonpsychiatrist physicians. The data were tabulated and statistically evaluated.

Table 1 presents the mean questionnaire scores for each of the three professional groups and the results of correlated t tests comparing their mean ratings. The exact wording of the questionnaire is included.

The ranking of topics by the three groups showed remarkable similarities. Each rated interviewing as the

TABLE 1
Mean Questionnaire Scores and Comparison of the Ratings of the Three Professional Groups

Information and Skills That a Nonpsychiatrist Physician Should Have	Scores*						t Values		
	Psychologists (N=18)		Psychiatrists (N=48)		Nonpsychiatrist Physicians (N=65)				
	Mean	SD	Mean	SD	Mean	SD	Psychologists–Psychiatrists	Psychiatrists–Nonpsychiatrist Physicians	Nonpsychiatrist Physicians–Psychologists
The ability to talk with patients about their personal problems	3.50	.70	3.62	.64	3.61	.72	0.69	0.07	0.60
The ability to distinguish between psychosis, neurosis, organic brain conditions, and character disorders	2.88	.96	2.93	.80	3.12	.85	0.21	1.16	1.00
A working knowledge of the community resources available for the care of emotionally disturbed individuals	2.61	.69	2.68	.80	2.53	.83	0.36	0.96	0.34
An awareness of psychodynamic principles in evaluating a patient's behavior	1.72	.66	2.08	.67	2.46	.86	1.93	2.51**	3.35***
The ability to evaluate a patient's potential for suicidal or destructive behavior or need for psychiatric hospitalization	3.38	.77	3.39	.73	3.06	.89	0.07	1.98†	1.40
An awareness of when and how to refer a patient to a psychiatrist	3.11	.90	3.47	.65	2.86	.89	1.83	4.04***	1.04
The ability to do brief psychotherapy	1.72	.57	2.16	.83	2.20	.90	2.08†	0.20	2.12†
A basic knowledge of current psychiatric treatment modalities	2.33	.76	2.10	.66	2.70	.79	1.20	0.68	0.63
An understanding of normal personality development	2.66	.68	2.43	.74	2.38	.84	1.14	0.35	1.30
An understanding of the principles of psychoanalytic theory	1.27	.42	1.50	.58	1.72	.83	1.84	1.58	2.44**
The ability to diagnose and treat family and marital disturbances	1.44	.89	2.12	.69	2.66	.85	3.89***	3.61***	5.76***
A working knowledge of common psychopharmacologic medications	3.30	.50	3.14	.71	2.84	.85	1.32	1.98†	2.57**
An understanding of sexual problems and their management	2.72	.89	2.75	.69	2.66	.85	0.13	0.59	0.26
The ability to diagnose and manage the mentally retarded	1.88	.67	1.91	.79	1.87	.89	0.13	0.24	0.05
A familiarity with the principles of behavior modification	2.33	.97	1.54	.54	2.01	.83	4.19***	3.42***	1.38
An understanding of the physiological concomitants of emotional stress	3.22	.64	3.02	.66	2.90	.93	1.10	0.72	1.34
A familiarity with the dynamics of the doctor-patient relationship	3.05	.80	3.31	.81	3.13	.80	1.25	1.19	0.39
An understanding of the emotional aspects of the chronically ill or dying patient	3.27	.82	3.41	.57	3.10	.81	0.74	2.25†	0.77
A familiarity with the major types and uses of psychological tests	1.94	.53	1.41	.53	1.98	.80	3.54***	4.25***	0.20
An understanding of the common behavior disorders of children and adolescents	2.55	.51	2.31	.62	2.41	.86	1.47	0.70	0.66
A basic knowledge of alcohol and drug abuse	3.00	.59	2.97	.75	2.84	.73	0.11	0.94	0.82

*The rating system is as follows: 1=not at all important, 2=moderately important, 3=very important, and 4=essential.
**p<.01.
***p<.001.
†p<.05.

most important skill to be learned. The 10 highest rated topics, although differing slightly in rank order, were the same in each group. The 10 included interviewing, suicide evaluation, psychopharmacology, the chronically ill or dying patient, psychophysiologic disorders, psychiatric referral, the doctor-patient relationship, drug and alcohol abuse, differential diagnosis, and sexual problems. The three groups agreed that child and adolescent disorders, community resources, and personality development were subjects of intermediate importance. All of the groups ranked mental retardation and psychoanalytic theory among the 5 least important subjects. Both the psycholo-

gists and the psychiatrists felt that the topic of psychodynamics was unimportant. Psychiatrists and nonpsychiatrist physicians indicated that it was "not at all important" for a physician to know about psychological testing and behavior modification.

Some statistically significant differences appeared when ratings by the three professional groups were compared. Psychiatrists felt that it was more important for nonpsychiatrist physicians to know about brief psychotherapy and family and marital problems than did the psychologists. Psychologists, on the other hand, felt that it was more important for nonpsychiatrist physicians to know about behavior modification and psychological testing than did the psychiatrists.

Psychiatrists and nonpsychiatrist physicians also differed to a significant degree on several items. The psychiatrists assigned more importance to the subjects of suicide evaluation, psychiatric referral, psychopharmacology, and the chronically ill and dying patient than did the nonpsychiatrist physicians. Nonpsychiatrist physicians rated marital problems, psychodynamics, and behavior modification and psychological tests slightly higher than did their psychiatric colleagues.

There were also several significant differences between psychologists and nonpsychiatrist physicians. Nonpsychiatrist physicians were more likely to rank psychodynamics, brief psychotherapy, psychoanalytic theory, and family and marital problems as important subjects to know. Psychologists believed that a knowledge of psychopharmacology was a more important subject than did the nonpsychiatrist physicians.

In addition to these findings, 28 respondents wrote in 1 or more additional topics that they felt were important. Seven suggested that physicians should be taught more about their own feeling responses to patients and physical illnesses. Three felt it important to be able to work closely with a psychiatrist in caring for certain types of medical patients. The remaining responses covered a range of topics.

DISCUSSION

An analysis of these survey data produced some noteworthy findings. Prominent among them was the degree of concurrence shown by the three groups in ranking the 21 topics. The same 10 subjects were given the highest ratings by each group and could quite suitably be designated as the core of any undergraduate psychiatric curriculum. Psychoanalytic theory and psychodynamics received uniformly low ratings. While the reasons for this unexpected finding are not clear, it appears that such theoretical concepts no longer hold the position of prominence in the medical school curricula that they did in former years.

In spite of the similar ratings given to many topics by the three groups, some significant interprofessional differences did appear. The data suggest that psychiatrists and psychologists manifested biases complementary to their particular disciplines that influenced their selection of topics.

This survey clearly designates the specific subjects that are suitable for inclusion in a psychiatric curriculum, but additional studies will be required. The physician's need to possess particular psychiatric knowledge or skills must be periodically reevaluated for relevance.

The uniformly low ratings given to some traditionally taught topics, i.e., mental retardation, psychoanalytic theory, and psychodynamics, deserve special consideration. The ratings suggest that either these subjects should be deleted from the undergraduate psychiatric curriculum or that special educational planning will be needed to make them more relevant for the practicing physician. Medical students may first have to be educated to need particular psychiatric knowledge before being formally taught it.

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Alternative to the Hospital: A Controlled Study

BY LEONARD I. STEIN, M.D., MARY ANN TEST, PH.D., AND ARNOLD J. MARX, M.D.

The authors describe the evaluation of a treatment model that makes use of the community to help mentally ill patients acquire necessary coping skills. This approach is based on the assumption that deficiency in coping skills and aggressive dependency are primarily responsible for high readmission rates to mental hospitals and that coping skills and autonomy are best learned in the community, where the patient will be needing and using them. The treatment model is evaluated by comparing it with progressive in-hospital treatment and follow-up care. The results suggest that the model described can successfully treat patients with a high level of symptomatology in the community rather than in the mental hospital.

IT IS EVIDENT that psychiatry is not successfully meeting the treatment needs of a substantial number of patients who come to public mental hospitals. In spite of recent innovative and intensive approaches, such as novel in-hospital programs (1–3), dramatic shortening of patients' hospital stay (4–6), and attempts to make use of community agencies for treatment (7), a sizable percentage of patients continue to spend considerable time in mental institutions, function poorly between admissions, and experience high readmission rates.

It is our contention that this persisting high rate of "treatment failures" is caused by the fact that existing models of treatment do not effectively ameliorate certain disabilities shared by many of these patients. These disabilities, which have been mentioned frequently in the literature (8–11), can be described in two ways: as a limited repertoire of instrumental and problem-solving behaviors to meet the goals and demands of life, leading to persisting difficulties with work habits, socialization, leisure-time activities, etc., and as powerful dependency needs, frequently expressed as an aggressive dependency on family or institutions.

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These problems lead to a tenuous community adjustment, keeping patients on the brink of rehospitalization. Patients thus disabled carry various diagnoses, ranging from schizophrenia to dependent personality. However, these disabling characteristics cut across diagnostic categories and can, in fact, represent the rock upon which treatment often founders. For example, the manifestations of an acute schizophrenic episode are managed relatively easily by means of phenothiazine drugs; however, if either a deficiency in coping skills or an aggressive dependency is also present, the problems of discharging and maintaining the patient in the community can be enormous.

In this paper we describe the evaluation of a clinical research program that is a radical departure from the present system of short-term hospitalization plus aftercare. The program, titled "Training in Community Living," was designed to help patients acquire the coping skills and autonomy necessary for a reasonable community adjustment. The model uses the community as a treatment arena; hospitalization is virtually eliminated. The rationale for this approach is based on theoretical and empirical work suggesting that the hospital itself frequently has a debilitating influence on patients (12–14) and, more importantly, that the community has much to offer as an arena for treatment of this population (15–17). The community, in contrast to the hospital, has stronger demand characteristics for appropriate behavior, has more healthy role models for the patients to emulate, and requires much less generalization to implement what is learned in treatment.

This new model for treating severely disturbed patients is being rigorously evaluated by comparing patients treated in the community with a control group receiving the presently available model of progressive in-hospital treatment of short duration plus aftercare services in the community. The relative success of the two models is being considered in terms of a number of patient outcome variables and in terms of social and economic costs. This paper outlines the clinical and research procedures and reports the results of the study to date.

METHOD

Subjects

The subjects for this ongoing study include all patients seeking admission for inpatient care at Mendota Mental Health Institute who meet the following criteria: 1) residence in Dane County, Wis., which consists of the city of

Madison and the surrounding area; 2) age of 18 to 62; and 3) any diagnosis other than severe organic brain syndrome or primary alcoholism.

Experimental Design

Patients meeting the above criteria are randomly assigned to either the community treatment group or the control group by the admission office staff. Control patients are treated in the hospital for as long as deemed necessary and then linked with appropriate community agencies. Experimental patients do not enter the hospital. They are treated according to the training in community living approach for 14 months, after which the staff are no longer available to them. Assessment data on all patients are gathered at baseline (time of admission) and every 4 months for a period of 36 months by means of personal interviews by a research staff. This staff operates independently of both clinical teams.

Control Treatment

Patients assigned to the control group are screened upon admission by a member of the hospital's acute treatment unit serving Dane County. The patients are usually, although not necessarily, admitted to the hospital, where they receive progressive treatment aimed at preparation for return to the community. The Dane County unit serves as a stringent control for the experimental program because it has a high staff-to-patient ratio and offers a wide variety of services, including inpatient treatment, partial hospitalization, and outpatient follow-up. It is by no means a custodial unit; its median length of stay is only 17 days. This unit also makes liberal use of the aftercare services available in Madison for discharged patients.

Experimental Treatment

Work with patients. Patients assigned to the community program are interviewed upon admission by a member of the experimental staff. They are then taken from the admission office to the community to begin their treatment program. Every effort is made to avoid hospitalization, which is used only for patients who are imminently suicidal or homicidal or who are so severely psychotic that they require high doses of medication that can be given only in the hospital's structured environment. In the rare instances when hospitalization is used, it is of short duration so that community treatment can begin with minimal delay.

The community treatment approach focuses directly on an in vivo teaching of coping skills as well as on treating the acute problem that precipitated the patient's coming to the hospital. The patient's treatment consists of participation in a full schedule of daily living activities in the community. Pharmacotherapy is used when appropriate.

The therapeutic input from the staff consists of motivating, supporting, and often being with the patients day and evening. More specifically, staff members, who are "on the spot" in patients' homes and neighborhoods, teach and assist them in such daily living activities as laundry upkeep, shopping, cooking, going to restaurants, grooming, budgeting, and use of transportation. Patients are also given sustained and intensive assistance in finding a job or placement in a sheltered workshop. Staff then continue daily contact with patients and their supervisors or employers to help with on-the-job problem solving.

Patients are aided in the constructive use of leisure time and the development of effective social skills by staff prodding and supporting their involvement in relevant community recreation and social activities. This frequently involves staff members' accompanying patients to such functions on a regular basis. In all of these activities, a "can do" philosophy is transmitted from staff to patient, the assets of the patients are stressed, and their symptomatology is played down. Daily, even hourly contact of staff with patients is emphasized initially and then gradually diminished according to each patient's progress in the treatment program.

The staff. To carry out the program, we retrained a mental hospital ward staff, which consisted of a psychiatrist, a psychologist, a social worker, an occupational therapist, nurses, and aides. These staff members spend their time dispersed throughout the community working with patients in such settings as their homes, their places of work, supermarkets, and recreational facilities. They help the patients learn the requisite skills to sustain a satisfactory community adjustment. Twice a day the staff members gather at the project's headquarters, a rented house in downtown Madison, to share information, revise treatment programs as necessary, and plan the next shift's work schedule. There are two shifts, so that the program is well staffed from 7 a.m. until 11 p.m., seven days a week. A member of the professional staff remains on call at night to give 24-hour-a-day coverage for patients as well as for community agencies.

Making use of mental hospital personnel in this kind of extro-hospital program has advantages as well as disadvantages. The advantages include the experience of mental hospital personnel in and commitment to working with severely ill patients and their orientation toward working with patient behaviors as well as feelings and cognitions. These workers are also experienced with a team approach; they are willing to rotate shifts so that the program can be operational at all times. The major disadvantage lies in the transition from work in a highly structured hospital setting, where little is required in the way of individual decision making, to work in the inevitably unstructured setting of the community, where a great deal of initiative and willingness to make decisions on the spot is vital. Fortunately, with training and support this transition was possible and the staff members increasingly welcome greater responsibility.

Community agencies. A program of this nature cannot survive unless the community is carefully prepared for its implementation. Before we conducted the pilot study (18) upon which this program is largely based, we held conferences with every relevant community agency to establish the closest of working relationships. Our major goal was to influence them to respond to the patients in a manner that would promote responsible behavior rather than re-

inforce maladaptive modes of coping with stress. For example, if a patient's behavior was disruptive to other tenants in his apartment building, we would encourage the landlord to talk to the patient directly about his behavior and tell him he would be evicted if it continued. This is in contrast to the community's usual response, which is to see to it that the patient's disruptive behavior leads to rehospitalization. That action implicitly gives the patient the message that he is not responsible for his behavior, teaches the patient a maladaptive mode of coping with stress, and reinforces the chronic patient role.

The manner in which we gained and maintained the cooperation of the supporting agencies in the community in relating to patients as described above is most clearly communicated by the following illustration:

The local sheltered workshop is an agency that we use frequently; we regard its cooperation as essential. Early in our work in community treatment, therefore, we met with the administrative staff of the workshop to discuss our philosophy of treating patients as responsible individuals and to obtain their sanction for our sending highly symptomatic patients to the workshop. After this was accomplished we enrolled several patients in the workshop and gradually developed effective techniques for maintaining the cooperation of this agency. We soon learned that even though we had gained support from the workshop administration, daily contact with floor supervisors was a necessary and useful endeavor because these individuals were relating directly to our patients. Throughout these contacts we urged workshop personnel to operate only in the area of their own expertise, rather than to relate to the patients as if they were therapists.

Our contacts with personnel at the workshop took the following forms: 1) structured meetings were held to review patient progress and to solve problems collaboratively, 2) a member of our staff frequently worked alongside our patients in the workshop as a model for the workshop staff and to discuss with them techniques useful in relating effectively with our patients, and 3) our staff was available on a round-the-clock basis to aid in the handling of crises and to provide assistance in any matter relevant to our patients. While such crisis contacts were usually initiated by a telephone call from workshop personnel, we often found it helpful to go immediately to the site of the problem to demonstrate our willingness to help.

Our assistance most often took the form of consulting with workshop personnel on how they might handle a patient rather than our directly intervening with the patient. Repeated supportive contacts such as these gradually assured the workshop staff that we were not dumping our work on them and provided valuable opportunities for training and problem solving. The result was that many workshop personnel became highly skilled in our training in community living techniques, and the number of crisis calls from this agency greatly diminished.

Modifications of these techniques of constant availability, modeling, support, and collaborative problem solving were successfully used to gain the active cooperation of a wide variety of individuals and agencies in the community. These included landlords, employers, social and recreational leaders, restaurant owners, vocational counselors, mental health workers, the staffs of local emergency rooms, the police, and the district attorney's office.

Summary of guidelines. The community treatment approach focuses directly on the patient disabilities discussed and thus adheres to the following guidelines:

In-hospital treatment, even with extremely symptomatic patients, is virtually eliminated so as not to reinforce dependency and to prevent institutionalization.

Treatment concentrates primarily on teaching coping skills necessary to live in the community and enjoy a reasonable quality of life. The learning of these skills takes place solely in the community.

Work with families and significant others is primarily directed toward the breaking of pathologically dependent relationships.

Staff members relate to patients as responsible individuals and make maximal efforts to expose them to the natural contingencies of living in society.

A close relationship is maintained with an exceptional variety of community facilities, from agencies to individuals, to ensure the consistency and continuity of our approach.

Staff members are assertive in their approach, not only to minimize the possibility of patients dropping out of treatment, but to maximize their engagement in responsible, independent community living.

Measuring Instruments

At the time of their admission to the study, we administer the following measuring instruments to the patients in each group:

Demographic data form. We devised this form to collect standard demographic data on the patients' life situation and economic status.

Short Clinical Rating Scale (19). This scale measures symptomatology. We used a summary scale of this measure, the global symptomatology rating, which is a 9-point scale in which 0 = none and 8 = severe.

Community adjustment form. We devised this form to assess the patient's living situation, how much time he had spent in institutions, his employment record, his social relationships, the quality of his environment, his subjective satisfaction with life, and what leisure-time activities he participated in.

Family Burden Scale. At one month, the Family Burden Scale is administered to the most significant other in the patient's family if that person lives in Dane County. We devised this 3-point scale to assess whether or not the experimental approach of treating the patient in the community places more of an emotional and economic burden on family members than does the control approach. A score of 1 on this scale indicates that the family feels no extra burden; a score of 3 indicates severe burden.

Every four months, the global symptomatology rating, the community adjustment form, and the Family Burden Scale are readministered.

TABLE 1
Demographic Characteristics of Experimental Group (N=60) and Control Group (N=60) at Time of Admission to the Study

Characteristic	Experimental Group	Control Group	Significance
Sex			n.s.*
Male	33	34	
Female	27	26	
Marital status			n.s.*
Single	30	28	
Married	14	16	
Divorced or separated	16	16	
Mean age	31.3, SD=10.4	30.6, SD=11.5	n.s.**
Mean number of months spent in psychiatric institutions before admission to study	15.3, SD=26.6	11.3, SD=26.3	n.s.**
Mean global symptomatology rating	4.7, SD=1.6	3.9, SD=1.6	p<.01**

*By chi-square test.
**By two-tailed t test.

TABLE 2
*Living Situations of Experimental Group (N=52) and Control Group (N=53) During First Four Months of Study**

Living Situation	Experimental Group Mean	Experimental Group SD	Control Group Mean	Control Group SD	Significance
Psychiatric institution	1.77	5.77	22.09	21.10	p<.001**
Medical institution	1.15	5.33	0.96	2.93	n.s.**
Penal institution	5.25	16.70	3.52	10.87	n.s.**
Supervised setting***	7.17	18.03	12.34	22.36	n.s.**
Independent setting	84.65	25.40	61.09	32.75	p<.001**

*Expressed as mean percent of four-month period ± SD; the Ns represent the number of patients in each group on whom interviews were completed.
**By two-tailed t test.
***Refers to such places as semisheltered boarding homes, halfway houses, and family care homes.

RESULTS

The results presented here represent data collected on the first 60 patients in each group during their first four months in the study. These results are important primarily as a measure of the feasibility of implementing our model as an alternative to treatment in a mental hospital.

Characteristics of the Sample

Relevant characteristics of patients in the two treatment groups at the time of admission to the study are presented in table 1. From this table it can be seen that the sample was relatively young, that most patients (approximately 75 percent) were either single, separated, or divorced, and that the patients had accumulated a substantial amount of time in psychiatric institutions before admission to this study.

The only variable on which patients in the experimental group differed significantly from the patients in the control group was global symptomatology: the experimental patients were somewhat more symptomatic than the control patients. This difference is viewed as conservative bias.

TABLE 3
*Employment Situations of Experimental Group (N=52) and Control Group (N=53) During First Four Months of Study**

Employment Situation	Experimental Group Mean	Experimental Group SD	Control Group Mean	Control Group SD	Significance
Unemployed	36.81	34.42	65.74	32.39	p<.001**
Sheltered employment	30.99	39.96	4.13	10.98	p<.001**
Competitive employment	32.32	38.19	30.04	32.05	n.s.**

*Expressed as mean percent of four-month period ± SD; the Ns represent the number of patients in each group on whom interviews were completed.
**By two-tailed t test.

Decision To Hospitalize

Only 6 of the 60 experimental patients were hospitalized in comparison with 54 of the 60 control patients (p<.001 by chi-square test). The 6 experimental patients spent a mean of 13.83 days in the hospital (SD=15.60), and the 54 control patients spent a mean of 22.87 days in the hospital (SD=20.35). Of the 54 control patients who were hospitalized, 14 were readmitted after being discharged within the first four months of the study, representing a readmission rate of 33 percent in four months.

Living Situation

Table 2 summarizes where patients lived during their first four months in the study. The amount of time spent in psychiatric hospitals was, of course, strikingly different in the two groups. There was no significant difference between the groups in the amount of time spent in medical or penal institutions. There was also no significant difference between the two groups in the amount of time spent in sheltered living situations. There was, however, a significant difference in the amount of time spent in independent settings: the experimental patients spent more time in independent settings than the control patients.

Employment Situation

The employment situation of patients in both groups during the first four months of study is shown in table 3. It can be seen that experimental patients spent significantly less time unemployed and significantly more time in sheltered employment than did control patients. There was no significant difference between groups in the amount of time spent in competitive employment. Follow-up data will show whether or not time spent in sheltered employment leads to competitive employment.

Other Measures

As was shown in table 1, both groups scored high (between "moderately" and "markedly" ill) upon entry into the study on the global symptomatology rating. By the end of four months patients in both groups revealed a sig-

nificant decrease in symptomatology, with no significant difference between groups on amount of improvement. Preliminary measures of social relationships, leisure-time activities, quality of environment, and subjective satisfaction with life also revealed no significant differences between groups at the end of four months.

Family Burden Scale

One month after entry into the study the burden felt by the families of both groups was almost identical. The 18 relatives of patients in the experimental group had a mean rating of 1.89 (SD=.76), and the 16 relatives of patients in the control group had a mean rating of 1.81 (SD=.75). At four months there was a significant decrease in the burden felt by families of experimental patients; their mean rating was 1.44 (SD=.70) ($p<.01$ by two-tailed t test). However, there was no such decrease in the burden felt by control families; their mean rating remained 1.81 (SD=.75). These results indicate that our community treatment approach did not place excessive stress on the families of experimental patients in comparison with the traditional approach ($p<.05$ by two-tailed t test).

The relatively small numbers of 18 and 16 for the families of experimental and control groups, respectively, reflect the fact that a high percentage of our patients do not have family living near them.

DISCUSSION

The above results clearly indicate that our extro-hospital model is a feasible alternative to mental hospital treatment. While other studies have demonstrated successful alternatives to the mental hospital for selected populations such as patients with families close-by (20–22), we used a randomly selected group of patients presenting for admission to a public hospital. Patients were included in the study regardless of symptomatology and regardless of the presence or absence of social resources.

While the longer range data currently being collected are certainly needed to assess the overall effectiveness of the model, the four-month data demonstrate that, in the new model, hospital stays were virtually eliminated, thereby reducing the disruption to life, the social stigma, and the reinforcement of dependency that result from hospitalization. The psychiatric hospital was used less, but there was no increase in the amount of time spent in penal institutions by our experimental patients, and no "mini-hospital" was created in the community. Rather, experimental patients spent most of their time in independent living situations, and the amount of time spent in overall productive functioning was increased. This was accomplished without reducing the individual patient's quality of life or his personal satisfaction with life. It is also important to note that this was accomplished without increasing the burden felt by the patient's family.

These results may be viewed as tautological: i.e., reduction of time in the hospital "creates" increased time in productive community living. To some extent this is true; however, the existence of third-rate boarding houses and hotels crowded with discharged mental patients makes it clear that simply being out of the hospital does not necessarily ensure satisfactory community functioning (23).

A cost-benefit analysis comparing the new model with traditional treatment is in progress to determine the economic feasibility of the program. Data from the economic study as well as data regarding the future clinical outcome of patients will be reported at a later time. Although the primary significance of the current data is in demonstrating that the training in community living model is a feasible alternative for patients who would otherwise be treated in public mental hospitals, it is our hope that the follow-up data will show that this model also enhances the long-range community adjustment of these patients.

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Prompt Publication Policy

The *Journal* would like to remind authors who are particularly interested in early publication (whether to establish priority of an idea, reveal innovative results of new research, or for other pressing reasons) of its prompt publication policy. Under this policy, short (maximum of six double-spaced pages) manuscripts will be considered for publication in the Brief Communications section of the first available issue. These manuscripts must still undergo expert scrutiny before being accepted, and two months must be allowed for the printing process. However, the time required for publication of these short articles can be lessened considerably.

Authors who would like to have their manuscripts considered under this policy should indicate this desire, as well as the reasons for it, when they submit their manuscripts.

Token Programs in an Acute Psychiatric Hospital

BY THOMAS J. CROWLEY, M.D.

The author has used individually prescribed token economies with about 5 percent of his acute psychiatric inpatients. Previous reports have dealt primarily with chronic patients. Case reviews indicated that patients chosen for these programs fell into four categories (which are illustrated by case histories): depressed complainers, apathetic and withdrawn patients, agitated psychotics, and impulsive, acting-out nonpsychotics. The author recommends techniques for patient selection, goal setting, and determination of reinforcers, and suggests that use of token programs may forestall the social breakdown syndrome in very disturbed patients.

DESPITE THE VARIETY of treatment modalities available in acute psychiatric hospitals, some patients still respond poorly. Token economy programs may provide a more intensely focused therapeutic milieu to forestall these difficult patients' continued regression into the "social breakdown syndrome" (1).

Such programs have been used primarily with chronically hospitalized patients who are paid tokens (poker chips, plastic scrip, etc.) as soon as they complete prescribed healthy behaviors. The tokens, which are redeemable for meals, passes, or other privileges, constitute immediate positive reinforcement for the behavior. Such programs focus on the successes rather than the failures of patients, they parallel the monetary reward system of society outside the hospital, and they provide a context for interpersonal treatment for relatively nonverbal patients who respond poorly to more traditional psychotherapy (2). Token economies have decreased psychotic behaviors and increased productivity and dignity for many chronically hospitalized patients (3–7).

There appear to be no reports of individualized token economy treatment in acute 24-hour hospitals, and I know of only one report of a ward-wide program in this type of hospital (8). This report retrospectively reviews the use of token programs in an acute hospital, suggesting criteria for patient selection and for choice of target behaviors and reinforcers, while providing impressions of outcome.

Revised version of a paper read at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich., May 6–10, 1974.

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METHOD

About 5 percent of the patients on a well-staffed ward in a university psychiatric hospital were selected for treatment in token programs. With experience, the ward staff developed some consensus as to which patients might respond to the treatment. This paper reviews 20 such cases treated over a 2-year period, comparing them with a sample of 50 consecutive admissions from the same period and attempting to retrospectively define the criteria that were used to select the patients. Techniques used in establishing the programs are outlined.

PATIENT CATEGORIES

The patients treated in the token programs fell into four general categories, which will be described and illustrated by case histories.

Complaining, Depressed Patients

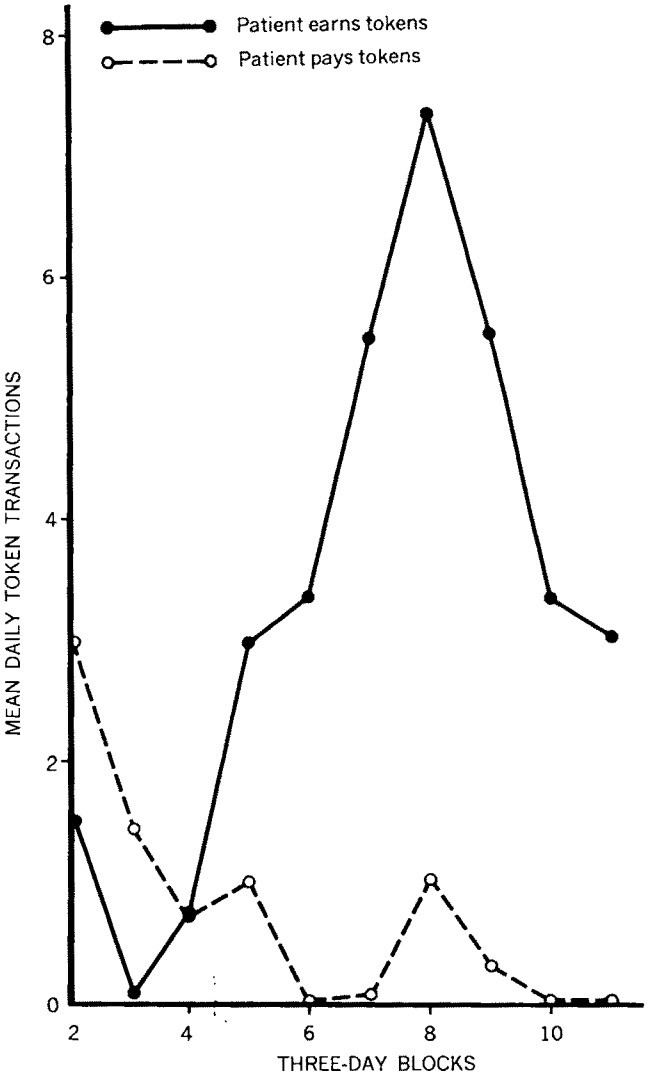
Of the 20 patients, 8 were chronically somatizing, helpless acting, inactive, depressed people. They were older than patients in the comparison group of 50 consecutive admissions (means = 57 and 33 years, respectively), and three-fourths had diagnoses of neurotic or psychotic depressions. Half had recently lost a spouse or other close relative and were alone or were having significant problems with remaining relatives.

Case 1. A 54-year-old woman who had been a widow for 1 year was living with a son who was arrested for drug dealing. Her lifelong cranky, pessimistic, complaining, and helpless behavior increased acutely, and she was admitted with agitation and depression. Previous depressions had responded to electroconvulsive therapy (ECT), but myocardial scleroderma with congestive heart failure now contraindicated ECT and tricyclic drugs. She responded little to other measures. Twenty days after admission, a token program was initiated to reward her for active, independent behaviors inconsistent with depression (see table 1). She earned poker chips for such behaviors and paid for certain privileges and for engaging in certain depressive behaviors on the ward. The family maintained the program when she was home on passes. Her complaints diminished and her positive behaviors increased, as is illustrated in figure 1, and she was discharged to a halfway house about a month later with her depression significantly improved.

TABLE 1
Token Program in Case 1, a Complaining, Depressed Patient

Target Behaviors	Number of Tokens Earned/Paid
Initial Program	
Patient earns tokens	
Listing personal positive attributes	1 per item
Talking positively about herself	2 per 5 minutes of conversation
Attending and participating in ward activities	2 per activity
Eating a meal with meat, milk, and vegetables	1 per meal
Playing cards	1 per game
Bonus for winning	1 per game
Initiating and supervising ward cooking projects	3 per project
Discussing problems constructively	1 per 5 minutes of conversation
Patient pays tokens	
Time on bed	2 per 15 minutes
Time with visitors	1 per 15 minutes
Time with resident	2 per 15 minutes
Complaints to staff	1 per complaint
Passes	2 per hour
Missing scheduled ward activities	3 per activity
Added later	
Patients earns tokens	
Fixing hair and make-up	1 each time
Taking a walk	1 per 10 minutes
Setting table and washing dishes when on a pass	1 each time
Discussing moving to halfway house	1 per 5 minutes conversation
Getting application for halfway house	10 per phone call
Getting help to make phone call to halfway house	1 per request
Patient pays tokens	
Complaints about program	1 per complaint
Saying, "You won't send me to the state hospital, will you?"	1 per question

FIGURE 1
*Token Transactions in Case 1, a Complaining, Depressed Patient**



*The patient earned tokens for making positive self-references and discussing solutions to problems and paid tokens for complaints. Data for the first 3-day block are deleted because of staff inconsistencies in payments and charges.

Withdrawn, Apathetic Patients

The 4 patients in this group averaged 26 years of age. Three had been diagnosed as having schizophrenia.

Case 2. A 21-year-old single woman who had been recently hospitalized once for a serious suicide attempt and once for posturing, ruminating, and social withdrawal was readmitted for depression. A home visit revealed that the patient could prepare food, sew curtains, etc., but received less attention from her parents for these activities than for her symptoms. She controlled the family through her symptoms; they felt that they had to do her bidding lest she attempt suicide again. Phenothiazines were continued, and 1 month after admission a token program was started to reward and encourage the healthy behaviors that her family had ignored. She earned tokens for 1) initiating conversations and speaking in group therapy, 2) occupational therapy projects, 3) listing her positive attributes, and 4) planning and taking steps toward school enrollment. She paid tokens for daytime spent on her bed, time with her doctor, and passes home. The family enthusiastically followed the program in the home when she was on passes and for several months after discharge. Her parents paid her tokens for studying, sewing, cooking, shopping, attending and socializing at school, etc. She could redeem the tokens for a cash allowance or for time to isolate at home watching TV, listening to records, or resting on her bed during the day. Two years after discharge she was in college making good grades and dating, and she had made several friends.

Agitated, Hyperactive Psychotic Patients

The 4 agitated, hyperactive psychotic patients had a mean age of 27. The group included 1 excited schizo-affective patient, 1 paranoid schizophrenic patient, and 2 manic patients.

Case 3. A 17-year-old boy whose parents had viewed him as peculiar for 10 to 12 years often locked himself in his bedroom or bathroom at home to avoid school, never ate with the family, and sometimes stayed away for days. He was arrested for swinging a baseball bat at cars in the middle of a busy street and

was angry, uncooperative, and apparently hallucinating on admission to the hospital. Antipsychotic medications were of no immediate help and because of increasing threats, combativeness, and disrobing, he eventually spent much of his time in a seclusion room. He sometimes said that he did not want to return to his parents, and he seemed to use the hospital and seclusion room to avoid them, as he had used the bathroom at home. A program was designed to serve three functions: 1) to permit him to be away from others without having to be "crazy," 2) to make human contact more pleasant, so that he would more often choose to be with others, and 3) to reestablish healthy behaviors that would help him in his contacts with people. He was to stay in seclusion except when he used tokens to buy half-hour blocks of time for activities he enjoyed such as ping-pong, reading, eating snacks, etc. He forfeited the purchase price if he was returned early to seclusion for threats or screaming. He earned tokens for being quiet in seclusion, for various personal hygiene activities, and for eating and taking medications regularly. The family agreed to visit briefly each night and to bring him a small gift whether he was in seclusion or not. He enjoyed the program and was observed hoarding, counting, and playing with his tokens. However, after 9 days of improvement, his parents missed two visits and he again became abusive and wild, increasing his seclusion time. He threw his tokens away, saying, "I'll teach my parents a lesson they'll never forget!"

When the parents were reenlisted in the program, the patient was systematically reinforced for slow but steady steps back into contact with ward staff and family. He eventually chose to return home, went there on passes, and was discharged after 104 hospital days. Seven months later he was making a marginal adjustment at home, neither working nor attending school.

Impulsive, Acting-Out Nonpsychotic Patients

These 4 patients, who averaged 26 years of age, had character or behavior disorders. Three eloped, two just before planned discharge.

Case 4. An 18-year-old mildly retarded girl was admitted when her father demanded placement out of the home after she had a "seizure" on the first day of a school year. She suffered seizures of both organic and psychological origin, and for months had had uncontrolled temper tantrums and staggering gait and refused to eat or maintain personal hygiene.

Raised initially in taverns by her mother, she was placed in a state school until her father took her home at the age of 14. She did well in special education classes, but during two years of regular school she cried and fought with her parents until she was physically restrained. This disturbed, antisocial behavior apparently gained considerable attention from the family and permitted the patient to avoid overly demanding classes.

After 5 hospital days of continued regressed behavior, a program was developed to selectively provide attention for useful, healthy social behaviors she would need in order to take special education classes. She earned tokens for attending ward activities, being up and dressed by 8 a.m., for personal hygiene activities, etc. She paid tokens to spend time on her bed, eat in her room, increase her privileges, use the TV or phone, etc. As her activity and mood improved, very structured family contacts were arranged. Eventually, she was earning tokens for going to special education classes, taking successful passes home, and applying for a work-study job. Four months after discharge she was attending school, working, and dating, but she had been put out of her father's house after a temper outburst and was living with a friend.

PATIENT SELECTION CRITERIA

Many patients who might have fit into the four categories I have described were not treated with token programs. The case reviews suggest that other factors also operated in the selection of the patients who were chosen for token programs.

First, the patients treated with token programs were quite disturbed. Psychotic affective and schizophrenic diagnoses were two times more common among them than among the comparison group ($\chi^2 = 6.34$, $p<.02$). Duration of stay, which correlates strongly on this ward with various indices of psychopathology (9), was 46 days versus 24 days for the comparison group ($p<.001$).

Second, the disturbed behaviors of these patients were usually acute exacerbations of long-standing habits. The complaining, depressed woman in case 1 had always been pessimistic. The agitated, psychotic boy's seclusion-seeking behavior (case 3) was an exaggerated form of his long-time habit of locking himself in the bathroom. Natural reinforcers in the patients' environments had maintained these chronic behavior patterns. The token programs reversed the contingencies to reinforce healthier activities. Nonhabitual behaviors that apparently arose de novo with the acute episode (e.g., acute hallucinations) were treated differently. For instance, stressful stimuli such as family pressures were reduced, while the patient's stress responses were altered with medications.

Third, token programs were used with patients whose affective behavior changed under various stimulus conditions. If an inactive depressed patient cheered up dramatically during family visits, for instance, we might pay the patient for daytime hours out of bed and charge him for visits with the family. Patients who were depressed under all conditions appeared to respond better to somatic treatments with a supportive, nondemanding milieu, as is illustrated by the following case example.

Case 5. A 64-year-old widow hospitalized with a psychotic, retarded depression responded excellently to 6 ECTs, but her symptoms returned when she had passes home with an angry, rejecting daughter who would not join in the treatment. Imipramine and triiodothyronine (10) were begun simultaneously with a token program to reinforce activity and improved family contacts. Symptoms progressed for 1 week, eventually appearing to be independent of immediate stimulus conditions. Four more ECTs resulted in improvement and discharge. This woman's token transactions (and general output of behavior) increased after the ECTs; the operant program seemed ineffective before ECT. Improved operant performance after physiological treatments has been reported previously (11).

Fourth, token programs were prescribed for patients whose environment reinforced them for staying "sick." Some patients use hospitalization not to solve problems but to avoid them. Impulsive or crazy behavior pays off by separating these patients from unpleasant outside environments. The girl in case 4 escaped from her rejecting parents into a relatively pleasant hospital where continued sick behavior could earn a continued stay. Programs

for such patients, who do notoriously poorly in short-term hospitals (12, 13), were designed to say, "You must work on your problems and act sane to stay here. You may buy the various privileges of hospitalization (a meal, use of a bed, TV, etc.) with tokens, and you can earn tokens only for specified healthy behaviors that will later help you overcome your problems on the outside." These patients had a clear choice: work on problems and "pay their way" with tokens, or don't work, don't earn, and be discharged, either to the home or (if there was dangerous behavior) to a chronic hospital. No patients chose the latter course.

Fifth, token programs were used with patients whose wild, impulsive hyperemotional or unpredictable behavior disrupted the usually empathic, warm, positively reinforcing behavior of the staff. When the staff started using angry, aversive methods of control, they put themselves on a program. They systematically reinforced the patient's healthy behaviors with tokens, while responding to wildness in an orderly way that was well thought out and explained in advance to the patient. These patients, who were often the products of unpredictable and aversively controlling environments, were now in an environment that attended actively to their successes and limited their uncontrolled behavior reasonably and in a highly predictable way.

Sixth, some residents preferred the preplanning and orderliness of token programs and prescribed them more often than did others.

SELECTION OF TREATMENT GOALS

The patients treated with token programs had not functioned well in the community before hospitalization. The hospital treatment goals were accordingly limited: to return patients to approximately their prehospital functional level, forestalling a progressive social breakdown. This general goal was usually met. Of these 20 very disturbed patients, 95 percent went home, to halfway houses, day treatment, or other outpatient dispositions. Only one was referred for long-term hospitalization.

Beyond this general goal, the programs were prescribed to reinforce progress toward the individual goals of specific patients. In the chronically hospitalized, it is difficult to know what behaviors to reinforce, for there is little to be done on back wards that is worth reinforcing (4). In acute patients, however, the history gives a behavioral baseline, and the current behavior can be viewed as a deviation from that baseline. The therapist and patient can develop a program to successively reinforce small changes in behavior toward the baseline.

Of the various symptoms—the various deviations from the behavioral baseline—which should be approached first, and how? Most "symptoms" can be defined either as an excess of one behavior or as a deficit of another, e.g., as an excess of isolation in bed or as a deficit in social interactions with others. The patient could be charged for isolating or paid for socializing; the latter is probably preferable in most cases.

Reinforcement can only increase the frequency of behaviors that are already occurring to some degree; behaviors that do not occur at all cannot be reinforced. Thus, reinforcement must begin "where the patient is at" behaviorally, and proceed stepwise from there. A patient who isolated in bed might first be reinforced for talking with staff from the bed, then for talking in the bedroom while out of bed, and finally for talking in the ward dayroom. This process of "shaping" behavior requires a clear final goal (e.g., talking with staff in the dayroom) and a clear understanding of the patient's current behavioral repertoire (e.g., only able to talk while lying in bed). The final goals would be those behaviors the patient would need in order to return to his prehospital functioning. The initial behaviors for systematic reinforcement should be those which are in the current behavioral repertoire of the patient and which are first steps toward the final goals.

The steps should be small. The "shaping" of the behavior of the impulsive girl (case 4) began with tokens for personal hygiene activities, getting up in the morning, etc. She was then paid for washing and ironing her clothes in addition to the personal hygiene activities and, eventually, for specific steps toward school. She remained at each level until she was performing well and with pride and at the next step was reinforced for doing just a little more.

The shaping procedure ends when the patient again behaves in ways that will permit him to live outside the hospital. However, patients need not be mechanically directed back to their prehospital situations. The depressed woman in case 1 chose to go to a halfway house rather than to return home. She was then successively reinforced with tokens for small steps toward this goal: getting off her bed, calling for application forms, planning a move, etc.

Skinner (14) recommends making better environments to make better men. The disturbed behavior of these patients was often unwittingly maintained by their families. Family therapy was directed at increasing the family's reinforcement of healthy behavior while decreasing their reinforcement for disturbed behavior, an approach that was especially successful with the family of the withdrawn girl (case 2). When token programs ignore family realities that militate against change, the patient may become dysphoric and perform poorly. Depression and anxiety are not "the reason" why the patient works poorly. Rather, the dysphoria and poor performance together indicate that mixed and conflicting reinforcement programs are operating in the patient's total environment of hospital and outside life. Few patients can change their entire lives in a brief hospitalization, but most wish to return to those activities and situations which formerly gave them pleasure. Treatment programs should help patients recover those pleasurable aspects of their lives, without requiring changes in the hospital that conflict with major reinforcement systems in the patient's outside life.

Circumstances precipitating hospitalization may prevent a return to the prehospital baseline. The depressed

patient's life (case 1) was irrevocably changed by her husband's death, and her efforts to live with various relatives failed. Her hospitalization was aimed at finding a rewarding living situation. The token program reestablished behaviors that would help her enter the halfway house she chose. A token program to change her in-hospital complaining behavior would probably have failed if it was not coupled with a plan to find a new living situation.

SELECTION OF REINFORCERS

What reinforces seriously disturbed behavior? In part, "craziness" may be defined as performing work to obtain very unusual reinforcers, such as being locked away (case 3 is an example). In one case a chronic patient who was offered discharge responded, "You're not going to railroad me out of here!" (15). Ludwig and associates (11) commented, "Our a priori conceptions of punishments have been accepted as rewards by patients, while rewards are taken as punishments."

Fortunately, Premack's principle (16) specifies what will reinforce behavior. It may be stated as follows: the opportunity to engage in a high-frequency behavior will reinforce a low-frequency behavior. In case 1, the depressed woman often stayed in bed or received family visits; these were high-frequency behaviors. She did little productive work in occupational therapy—a low-frequency behavior. Therefore, she was paid for OT work with tokens redeemable for bed-rest time or family visits. The purpose obviously was not to eliminate family visits, or even bed rest (which was excessive), but rather to effectively reinforce low-frequency behaviors of activity and self-reliance.

Most of the reported programs for chronic patients have been set up on a wardwide basis. The programs I have described were individually prescribed to help patients reach their personal goals and were based on an understanding of individual patients that came from an analysis of the particular behavioral frequencies in the baseline and current state of each patient. Appendix 1 lists behaviors for which these 20 patients earned or paid tokens. Many behaviors appear in both lists. Some patients who frequently requested passes home have purchased passes with tokens earned through important low-frequency behaviors, such as arranging for a job. But patients who avoided outside problems through hospitalization earned tokens for successful passes home; they could then purchase time for specified high-frequency behaviors on the ward, such as watching TV.

Many of these patients surprisingly continued to earn tokens even after building up a sizable "bank account." Several patients literally broke the bank, exhausting the staff's supply of poker chips. These patients, who had often been treated as failures by those around them, expressed pleasure with the tokens as concrete evidence that they were seen as successful by the staff. It is probable that the social interactions with staff members who gave the tokens came to be a significant reinforcer, and staff members were careful to provide smiles and congratulations for progress when giving tokens.

SUMMARY AND CONCLUSIONS

This review of our work suggests certain steps in establishing a token program for an acute psychiatric inpatient.

1. Ascertain that the patient responds poorly to a less structured therapeutic milieu and fits a category and some of the additional criteria given earlier in this paper.
2. Assess his past history and prehospital baseline functioning.
3. Determine what changed in his life to cause a change in his baseline behavior.
4. Set with him a general goal to help him return to or near his baseline. If permanent losses precipitated hospitalization, aim to help him find a satisfactory replacement for what he lost.
5. To set specific goals, begin by counting his current behaviors. Determine which important ones occur in excess, and which in deficit, compared to the baseline.
6. Systematically pay him tokens whenever he performs important behaviors that are in deficit.
7. Permit him to redeem these tokens for the opportunity to engage in his high-frequency behaviors, whether or not they seem "healthy."
8. Charge tokens for behaviors occurring in excess over his baseline rate.
9. Begin by reinforcing him reasonably for his present level of functioning; change the program gradually to reinforce small steps back toward the behavioral baseline.
10. Prescribe family interactions to reinforce a return to the baseline.
11. Discontinue the program when more natural social reinforcers are again maintaining baseline behavior.

Many of these same steps, of course, are implicit in the milieu treatment of any acute psychiatric patient. But the token exchanges require greater clarity, consistency, and precision in the staff's definition of the treatment plan. This provides the patient with a clearer view of treatment goals and techniques, permitting him to participate more actively in shaping the course of the treatment.

This uncontrolled report on techniques for developing token programs cannot really establish their efficacy in treating acute psychiatric inpatients, but the method does appear promising. The return of 95 percent of these rather disturbed patients to the community suggests value for token programs in forestalling the social breakdown syndrome.

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APPENDIX 1
Behaviors for Token Transactions

BEHAVIORS FOR WHICH PATIENTS HAVE EARNED TOKENS	BEHAVIORS FOR WHICH PATIENTS HAVE PAID TOKENS
1. Personal Hygiene	
Get up in morning, dress, brush teeth, make bed, wash and iron clothes.	Select street clothes, shower.
2. Ward Activities	
Attend occupational or recreational therapy groups, talk there, be quiet there. Eat out of seclusion, eat in cafeteria. Use dayroom, stay out of bedroom, quiet on ward, cleaning, cooking.	Attend groups, individual therapy. Talk with nursing staff. Eat in ward rather than cafeteria. Time to isolate self. Bowling. Use of favorite chair, TV, cigarettes, stereo. One day of hospital stay.
3. Physical Care Activities	
Cooperate in medical work-up, in taking antipsychotic drugs or disulfiram, requesting prescribed medications. In bed at night. Eat well. Exercise.	Use of home remedies, sedatives, stimulants. Eat meals, skip meals, snacking, drink coffee. Forget medications. Refuse recommended rest.
4. Attitude-Changing Behaviors	
Discuss a solution while discussing a problem. List positive attributes of self, others. List advantages, disadvantages of work versus welfare. Hopeful talk. Compliment or do things for others. Chart mood changes.	Complaining, discuss physical symptoms, manipulative suicide talk.
5. Self-Control Behaviors	
Stay out of seclusion, stick to privileges. Refrain from fighting.	Hurt self, have matches.
6. Social Behavior on Ward	
Socialize with staff, patients. Converse without arguing, complaining, or acting confused.	
7. Family Interactions	
Call family. Arrange family visit in hospital, pass, activities at home. Eye contact with family. Avoid arguments with family.	Pass home, family visit. Call family to complain; call to family if patient doesn't say "thank you" during conversation.
8. Leaving Hospital	
Walk outside, request more privileges, request changes in behavior program. Accomplish personal business on pass. Socialize away from hospital. Accomplish steps toward job, work, living situation. Go to work.	Passes, more privileges, walks outside.

Cardiovascular Malformations with Lithium Use During Pregnancy

BY MORTON R. WEINSTEIN, M.D., AND MICHAEL D. GOLDFIELD, M.D.

The 143 cases of lithium use during pregnancy collected by the Register of Lithium Babies show that infants exposed to lithium appear to have a higher than expected ratio of cardiovascular anomalies to all anomalies and may have an increased risk of congenital heart disease. The authors believe that these findings justify a conservative policy on the use of lithium with fertile and pregnant women.

IN COLLABORATION WITH colleagues in Denmark and Canada, we have for several years been soliciting information about infants exposed to lithium carbonate in utero. A total of 150 such reports have now been received; of these, 143 met the following criteria and have been incorporated into the Register of Lithium Babies: 1) lithium ingestion by the mother at least some time during the first trimester of pregnancy, and 2) the availability of the infant or fetus or sufficient fetal tissue to permit identification of significant anomalies.

Through a series of reports (1–6), the register has been brought to the attention of those likely to encounter "lithium babies." Also, all hospitals with AMA-approved obstetrical and pediatric internships and residencies were contacted twice in the last two years with information about the register and forms for reporting lithium babies to it. Each hospital department was also asked to designate a staff member to serve as liaison with the register.

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Several articles have described the work of the register since its inception (3, 6, 7). These earlier reports acknowledged that data gathered by a register of this kind could not generate reliable information about the incidence of anomalies in infants exposed to lithium. However, they noted that a register could give early warning if the alarming frequency (30 to 60 percent) of fetal anomalies and maternal and fetal deaths reported in rodents exposed in utero to lithium also occurred in human fetuses exposed to the drug (8, 9). It became reassuringly clear early in the work of the register that this was not the case, but on the basis of earlier analyses of material in the register we recommended a conservative approach to the use of lithium in fertile women, discontinuation of lithium in the first trimester if possible, and avoidance of breast-feeding by lithium-treated mothers (5, 7). However, we did not believe the evidence then at hand warranted termination of pregnancy because of lithium exposure alone, and we did not feel that lithium treatment should *always* be interrupted when a pregnancy occurred.

INCIDENCE OF CARDIOVASCULAR ABNORMALITIES

However, recent additions to the register have supported the view that there is an unexpectedly high proportion of major cardiovascular abnormalities among the malformed infants reported. The characteristics of the malformed lithium babies are presented in table 1, which shows that there are 13 malformed infants among the 143 in the register (9.1 percent).

Two of these babies (subjects 3 and 4) had anomalies of the central nervous system and of the external ears, respectively. The 11 other infants were born with significant malformations of the cardiovascular system (7.7 percent of all register entries and 85 percent of all of the malformed infants). Of the 11 with cardiovascular anomalies, 10 had major abnormalities of the heart and great

The papers in this section are grouped around a specific topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.

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TABLE 1
Data on Malformed Infants From the Register of Lithium Babies

Subject	Birth Date	Other Drugs Used During Pregnancy	Sex	Weight	Type of Malformation	Child's Fate	Source of Report
1	3/9/69	—	Female	—	Coarctation of the aorta	Malformation corrected with surgery	U.S.A.
2	5/22/69	—	Male	6 lbs. 2 oz.	High intraventricular septal defect	Died on day 4	U.S.A.
3	8/23/69	Chlorpromazine, diuretics	Female	6 lbs. 13 oz.	Stenosis of aqueduct with hydrocephalus, spina bifida with sacral meningo-myelocele, bilateral talipes equinovarus with paralysis	—	Canada
4	9/28/69	None	Male	7 lbs. 11 oz.	Unilateral microtia	Developing normally at age 3, apart from the malformed ear	Denmark
5	1/30/71	Nortriptyline, diazepam	Female	5 lbs. 6 oz.	Mitral atresia, rudimentary left ventricle without inlet or outlet, aorta and pulmonary artery arising from right ventricle, patent ductus arteriosus, left superior vena cava	Died on day 5	U.S.A.
6	2/—/71	Haloperidol, nortriptyline, barbiturates, and others	—	—	Mitral atresia	Died soon after corrective surgery	U.S.A.
7	2/23/71	None	Female	6 lbs. 11 oz.	Ebstein's anomaly	Died a few days after birth	U.S.A.
8	9/28/71	—	Male	4 lbs. 13 oz.	Single umbilical artery, bilateral hypoplasia of maxilla	Died 5 hours after birth	Canada
9	2/22/72	Amitriptyline	Female	7 lbs. 8 oz.	Ebstein's anomaly	Died 1 day after birth	Denmark
10	5/23/72	None	Female	4 lbs. 13 oz.	Atresia of tricuspid valve	Stillborn	Denmark
11	11/8/72	None*	Female	7 lbs. 0 oz.	Ebstein's anomaly	—	U.S.A.
12	1/18/73	Nortriptyline**	Female	7 lbs. 8 oz.	Patent ductus arteriosus, ventricular septal defect	Survived 3 months as of report	England
13	6/30/74	Trifluoperazine	Female	8 lbs. 14 oz.	Ebstein's anomaly	—	U.S.A.

*The mother was a "gestational diabetic."
**The mother was 39 at time of pregnancy.

vessels, and the other (subject 8) had a single umbilical artery. Information about the use of other drugs during pregnancy was available for 10 of the 13 malformed infants; 6 of these had been exposed to medications other than lithium, and in another instance (subject 11) the mother had "gestational diabetes." It is especially noteworthy that 4 cases of Ebstein's anomaly (subjects 7, 9, 11, and 13) have been reported to the register (10, 11). This rare malformation (10, 12) consists of a distorted and displaced tricuspid valve, with secondary abnormalities of the right ventricle and atrium. Atrial septal defect or patent foramen ovale may also be present.

Reports to a register such as this will tend to exaggerate pathology, and data gathered in this way do not permit inferences or conclusions about the true incidence of any pathological state in the reporting population. However, the ratios among kinds or classes of pathology in the register should be similar to the corresponding ratios in the reporting population, and studies of general as well as selected populations of neonates consistently show that major anomalies of the cardiovascular system represent a minority of all nontrivial congenital anomalies (13–16).

Synthesized data from several studies in which infants were examined carefully at birth and during the first week of life (13–17) indicate that the incidence of all nontrivial anomalies in such infants is about 30 per 1,000 births; the incidence of congenital heart disease is about 4 per 1,000 births; the incidence of tricuspid atresia is about .09 per 1,000 births; and the incidence of Ebstein's anomaly is about .05 per 1,000 births. Overall, therefore, the ratio of Ebstein's anomaly to all nontrivial anomalies is about 1:600, the ratio of Ebstein's anomaly to all forms of congenital heart disease is about 1:80, and the ratio of congenital heart disease to all nontrivial malformations is about 1:8.

In contrast, in the Register of Lithium Babies the ratio of Ebstein's anomaly to all reported nontrivial anomalies is 1:3.3, the ratio of Ebstein's anomaly to all forms of congenital heart disease is 1:2.5, and the ratio of congenital heart disease to all nontrivial malformations is 1:1.3. In the register the ratio of malformations of the tricuspid valve/tricuspid atresia (subjects 7, 9, 10, 11, and 13) to all cardiac anomalies is about 1:2, while the ratio of tricuspid atresia to all congenital heart defects in baseline studies (12, 14–16) is about 1:44 (see table 2).

TABLE 2
Ratios Between Various Malformations

Malformations	Register of Lithium Babies	Expected (10–17)
Ebstein's anomaly to all nontrivial anomalies	1:3.3	1:600
Ebstein's anomaly to all forms of congenital heart disease	1:2.5	1:80
Malformations of the tricuspid valve/tricuspid atresia to all forms of congenital heart disease	1:2.0	1:44
All forms of congenital heart disease to all nontrivial anomalies	1:1.3	1:8

DISCUSSION

We cannot say with certainty that congenital cardiovascular anomalies occur in infants exposed to lithium more often than in nonexposed infants, but it seems very likely that they do. The alternatives to this conclusion are to assume 1) that abnormal babies are more assiduously reported than are normal babies and that dramatic abnormalities (such as Ebstein's anomaly) are reported more completely than are less impressive defects, 2) that exposure to lithium protects the fetus against malformations other than those of a cardiovascular nature, or 3) that there is an association between manic-depressive illness and cardiovascular anomalies independent of lithium exposure. The first of these possibilities is very likely true and is discussed elsewhere (6, 7). The other two possibilities merit investigation.

Meanwhile, we believe that the apparent overrepresentation of important cardiovascular anomalies among malformed lithium babies confirms and strengthens our earlier recommendations for caution in the exposure of pregnant or potentially pregnant women to lithium.

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Drug-Induced Dystonia

BY CHESTER SWETT, JR., M.D.

Among 1,152 psychiatric inpatients who received a phenothiazine, a butyrophenone, or a thioxanthene, 116 developed dystonia attributed to one or more of these drugs. The highest frequencies of dystonia occurred among recipients of haloperidol and the long-acting injectable fluphenazines. For all patients at risk, dystonia was more common in men and in younger patients. For chlorpromazine, high doses, male sex, and low age were each positively associated with dystonia.

DYSTONIA IS A well-known side effect to certain psychotropic drugs. In one large survey (1), 2.3 percent of 3,775 patients developed dystonia attributed to phenothiazines. The present report describes the occurrence of dystonia among 1,152 psychiatric inpatients who were exposed to a butyrophenone, to phenothiazines, or to thioxanthenes.

METHOD

The methods employed by the Boston Collaborative Drug Surveillance Program[1] (BCDSP) in general hospitals have been described in detail (2); they are similar to those used in psychiatric hospitals. Nurse monitors are stationed in selected psychiatric wards in a number of hospitals where they collect information (various descriptive characteristics of each patient, diagnoses, and details of all drug administrations) on consecutively admitted patients. When each drug is started, the monitor interviews the attending physician to obtain the indication; when a drug is stopped, she asks him/her whether or not an adverse reaction (any unwanted or unintended effect of a drug) occurred. All suspected reactions are evaluated by a team from the BCDSP.

Dystonia is the acute onset of a tonic contraction of a muscle or muscle group. In this study, when more than one drug-induced dystonia occurred during a patient's hospitalization, only the first reaction was considered.

This report is based on data gathered on 1,708 consecutively monitored psychiatric inpatients in five hospitals in the United States; 1,152 (67 percent) had received a butyrophenone, phenothiazine, or thioxanthene.

[1]Psychiatric hospitals that participated in the BCDSP were Boston State Hospital, Massachusetts Mental Health Center (Boston, Mass.), Hesperian Hospital (Helsinki, Finland), Jackson Memorial Hospital (Miami, Fla.), Mayo Memorial Hospital (Minneapolis, Minn.), and New York University Medical Center.

RESULTS

Of the 1,152 patients, 116 (10.1 percent) had drug-induced dystonia. The mean age of all patients was 37 years, and 55 percent were women. The mean length of stay until discharge from the study was 48 days. The primary diagnoses on discharge were schizophrenia (61 percent), affective psychosis (13 percent), and reactive depression (4 percent). A wide variety of diagnoses accounted for the remainder (22 percent). The most common indications for drug administration were thought disorder (48 percent), agitation (22 percent), and paranoid ideation (12 percent).

The types of dystonia were torticollis (N=35), swollen tongue (N=20), trismus (N=17), oculogyric crisis (N=7), and opisthotonos (N=4); a variety of dystonic symptoms in various muscle groups accounted for the remainder (N=33).

The frequencies of dystonia attributed to various drugs are given in table 1. Other than drugs received by fewer than 50 patients, the highest frequency occurred among patients who received the butyrophenone haloperidol (16.0 percent). Higher frequencies of dystonia were observed among those phenothiazine recipients who received drugs with a piperazine side chain such as the long-acting injectable fluphenazine enanthate (11.7 percent) and trifluoperazine (8.2 percent). One exception, however, was a frequency of 2.5 percent among 80 recipients of fluphenazine hydrochloride. Generally lower frequencies were observed among those who received chlorpromazine (3.5 percent), which has an aliphatic side chain, and thioridazine (0.6 percent), which has a piperidine side chain. A total of 13 patients had dystonia attributed to more than one drug; in none of them was the combination the same.

As shown in table 2, the patients were divided according to sex and age (under 30 years, 30 to 49 years, and 50 years or over). Among patients aged 50 years or more, the rates of dystonia were similar in men and women. In

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TABLE 1
Frequency of Dystonia Attributed to Various Drugs

Drug	Number of Patients Taking the Drug	Patients with Dystonia*	
		Number	Percent
Butyrophenone			
Haloperidol	200	32	16.0
Phenothiazines			
Piperazine side chain			
Fluphenazine enanthate	137	16	11.7
Fluphenazine decanoate	4	1	25.0
Fluphenazine hydrochloride	80	2	2.5
Trifluoperazine	219	18	8.2
Perphenazine	89	5	5.6
Aliphatic side chain			
Chlorpromazine	679	24	3.5
Piperidine side chain			
Thioridazine	313	2	0.6
Mesoridazine	20	1	5.0
Thioxanthenes			
Thiothixene	24	2	8.3
Chlorprothixene	2	0	0.0

*Thirteen patients developed dystonia that was attributed to combinations of two or more drugs.

TABLE 2
Frequency of Dystonia by Age and Sex

Age (years)*	Men		Women	
	Number of Patients	Percent with Dystonia	Number of Patients	Percent with Dystonia
Less than 30	259	20.5	206	12.6
30–49	174	8.1	241	4.6
50 and older	87	4.6	184	4.4

*The age of one patient was unknown.

TABLE 3
Frequency of Dystonia Attributed to Chlorpromazine by Age, Dose, and Sex

Age (years)	Daily Dosage (mg)	Men		Women	
		Number of Patients	Percent with Dystonia	Number of Patients	Percent with Dystonia
Less than 30	Less than 100	44	6.8	31	0.0
	100–299	66	4.5	48	4.2
	300 and above	47	14.9	18	11.1
30 and older	Less than 100	67	0.0	110	0.0
	100–299	54	1.9	88	0.0
	300 and above	46	10.9	60	1.7

the remaining two age categories, dystonia was more common in men. The sex-specific frequencies of dystonia were highest in the youngest patients, intermediate in patients aged 30 to 49 years, and lowest in the oldest patients.

The independent influences of age, sex, and dose were evaluated by selecting the most commonly used drug, chlorpromazine, for more detailed analysis. For those with dystonia attributed to chlorpromazine, the total dose used in the 24 hours before the reaction was compared with the dose received on the first day. On both the reacting day and the first day, 14 of the 24 reactors received 300 mg or more; 11 patients had a reaction on the first day. Furthermore, the mean reacting dose of chlorpromazine was 379 mg, SE=54; the corresponding mean dose for the first day of therapy was 334 mg, SE=39. Since these two values were similar, the dose selected for analysis in the nonreactors was the one received in the first 24 hours of treatment.

In table 3 the data have been stratified according to age, daily dosage, and sex. With a multiple logistic regression analysis (3) to simultaneously control these three variables, the frequency of dystonia was significantly higher among those who received daily doses of 300 mg or more compared to those who received 100 mg or less ($p<.05$). The frequencies were also significantly higher among patients below the age of 30 years ($p<.05$) and among men ($p<.05$).

The duration of therapy until onset of a reaction was 4 days or less in 85 percent of the cases and 15 days or less in 96 percent. A number of other factors, including prior outpatient use of medication, use of multiple neuroleptic drugs during hospitalization, blood urea nitrogen, and race were evaluated. None of them influenced the results.

Because of the occurrence of dystonia, the attending physician discontinued the drug or decreased the dose in 25 percent of the cases. In addition, 99 patients (85 percent) were treated with antiparkinsonian agents, i.e., benztropine mesylate (N=51), diphenhydramine (N=15), trihexyphenidyl (N=10), or a combination (N=23).

DISCUSSION

Drug-induced dystonia was found to be more common in this survey than in previous reports (1; 4, p. 149), probably because of the recent introduction of haloperidol and the long-acting injectable fluphenazine enanthate. It is probable that these data indicate an actual rise in frequency of drug-induced dystonia following the introduction of these two drugs.

Overall, the data confirm previous reports that among patients at risk, dystonia is more common in men and in younger patients, and the risk appears to decrease with increasing age. However, it is possible that these observations can be accounted for by differential dosage according to sex and age.

To further evaluate the independent effects of dose, sex, and age, chlorpromazine (the most commonly used

drug) was selected for multivariate analysis. The risk of dystonia was indeed related to dosage—patients who received daily doses of 300 mg or higher more commonly had dystonia. However, even when allowance was made for the influence of dosage, the sex- and age-specific side effects remained; i.e., dystonia was significantly more common in men and in younger patients. A dose effect has not been previously reported, although other studies (5, 6) have shown that the extrapyramidal reactions, as a group, are more commonly observed with large, cumulative doses of phenothiazines. It is possible that other studies have failed to identify a dose effect because age and sex were not considered.

As has been reported for extrapyramidal reactions in general (1, 7), the frequency of dystonia was highest for those who received haloperidol, generally high among phenothiazine recipients who were administered derivatives of piperazine, lower in those who received aliphatics, and still lower in those who received piperidines. There were too few recipients of thioxanthenes for the reaction rates to represent stable frequencies.

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Atypical Tardive Dyskinesia

BY RONALD A. MOLINE, M.D.

The author reports an atypical case of tardive dyskinesia in a 19-year-old male who had been given relatively low dosages of neuroleptic medication for less than 6 months. The symptoms cleared within 3 months after the medication was discontinued. The author reviews the literature regarding similar atypical cases and suggests that increased reporting and careful description of such cases might be useful in furthering our understanding of this syndrome.

IN 1968 CRANE (1) reviewed the literature and found 23 reports encompassing over 500 patients of the symptom complex that Uhrbrand and Faurbye (2) had labeled tardive dyskinesia 8 years earlier. In his review, Crane noted that 1) the syndrome occurred predominantly in older patients who had been on neuroleptic medication for prolonged periods and in high doses, 2) there was a higher incidence among brain-damaged individuals, and 3) women with the syndrome outnumbered men 3 to 1. He also pointed out, however, that there were reports of the syndrome in individuals as young as 27 and occasionally in patients who had received relatively little neuroleptic medication. One such patient was reported as developing this symptom complex after 4 months of therapy with 4 mg of trifluoperazine daily.

In the past several years, there has been a proliferation of reports on this syndrome from many different countries confirming the central findings Crane reported (3–7). Many articles have also appeared in the literature affirming the irreversible nature of this phenomenon (8, 9) and the lack of response to various attempts at treatment (10, 11). The following is an unusual case in that it runs counter to the prevailing literature in several aspects: age of onset, dosage of neuroleptics preceding onset, and reversibility.

CASE REPORT

A.B., a 19-year-old single male, was admitted to the psychiatric unit because of increasing belligerence toward his parents,

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culminating in his entering their bedroom one night and striking his mother. He had a history of markedly diminished functioning after high school (where he had achieved scholastic excellence), marked obsessive-compulsive ritualistic behavior, and constricted, repetitive ideational content. On admission, findings of a physical examination were unremarkable, with the exception of moderate gynecomastia. Other primary and secondary sexual characteristics were normal. Routine laboratory findings were unremarkable. An EEG was reported as showing paroxysmal low-voltage slow activity in both frontoparietal areas. Skull films and repeated neurological examinations were negative.

In his first psychiatric hospitalization (at another institution 10 months before), he had been placed on 6 mg of trifluoperazine daily and 100 mg of chlorpromazine daily. Two days later, for reasons not clear from the record, this regimen was discontinued and the patient was given 150 mg of piperacetazine daily and 2 mg of benztropine daily. Piperacetazine was lowered to 100 mg daily after 10 days and to 75 mg daily 5 days later. He was discharged on this medication 52 days after admission. During that hospitalization, he also occasionally received 75 mg of chlorpromazine as needed. According to the patient and his family, he continued to take his medication after discharge only sporadically, stopping altogether within a few weeks.

At the time of his admission to our hospital, our impression was that the patient was in the early stages of a schizophrenic decompensation. He was placed on 100 mg of chlorpromazine at bedtime for 1 week. This was increased to 600 mg for 1 day and then discontinued and the patient was started on 7 mg of haloperidol and 1 mg of benztropine daily. Slightly more than 3 months after it was begun, the haloperidol was discontinued because of marked parkinsonism and a question of facio-lingual dyskinesia. The parkinsonism improved within 3 days, but the oral symptoms worsened markedly, with protrusion of the tongue, chewing movements, movement of the chin, and contraction of the upper lip exposing the upper teeth. In addition, the patient exhibited rocking movements when seated, spoke for the first time of wanting to become a monk, and became preoccupied with evangelical religious tract literature.

After 4 months, the mouth movements and mental status were greatly improved.[1] The benztropine was also discontinued at that time, without apparent effect. Two months later, the symptoms had cleared completely.

DISCUSSION

Crane (12) documented a case of a 41-year-old woman who developed tardive dyskinesia after less than a year of neuroleptic medication, and whose symptoms subsequently cleared completely. Simpson (13) also reported the syndrome developing within 6 months of beginning treatment, with symptoms clearing after treatment was discontinued; however, the cases were not documented in his report. He also reported a neurotic patient who was given up to 10 mg of trifluoperazine for under a year and developed tardive dyskinesia that did not remit. Other authors have reported patients who developed the syndrome after relatively low dosages of neuroleptic medication, but who were on medication for more than 1 year (14, 15).

In 1968, Kline (16) questioned whether the irreversibility of this syndrome had been adequately documented. Although the subsequent literature has abundantly delineated an irreversible syndrome occurring in older patients on prolonged regimens of neuroleptic medication, the cases I have referred to, together with the case report in this paper, must also be accounted for in any attempt to define and theorize about tardive dyskinesia. Previous reports of exceptional cases have tended to be brief and fragmentary, possibly contributing to the tendency in the literature to equate the typical syndrome with the syndrome in its entirety. It is apparent that such a viewpoint could easily lend itself to faulty hypothesis formation, such as the assumption that the appearance of symptoms is indicative of irreversible changes in brain tissue. Further elucidation of this most recent of iatrogenic syndromes in psychiatry could perhaps result from increased careful description of exceptional cases in addition to studies of the typical syndrome.

[1]At this point, Dr. G.E. Crane visited the facility and examined this patient, confirming our diagnosis of tardive dyskinesia.

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Cogwheel Rigidity Related to Lithium Maintenance

BY BARON SHOPSIN, M.D., AND SAMUEL GERSHON, M.D.

Neurological examinations of 27 outpatients receiving lithium carbonate maintenance therapy for recurrent affective illness revealed that most of the patients receiving lithium for more than 8 months had cogwheel rigidity. The data suggest a positive correlation between the duration of lithium maintenance and the severity of cogwheeling. Intravenous administration of benztropine, an antiparkinsonian drug, did not abolish or significantly ameliorate this symptom.

LITHIUM CARBONATE is now an established modality in the treatment and prophylaxis of manic-depressive disorder. Extrapyramidal symptoms have not been among the many side effects reported to be attendant upon the use of this ion. Essential tremor has been reported (1); the absence of response to antiparkinsonian drugs has contributed to the conclusion that the tremor is not related to the extrapyramidal system.

During the past 6 months we have conducted neurological examinations of our outpatients who are receiving lithium maintenance therapy. The following data from a preliminary study are reported because they suggest that long-term lithium maintenance can be accompanied by cogwheel rigidity, which implies involvement of the extrapyramidal system. This symptom does not subside with the use of intravenously administered antiparkinsonian drugs.

METHOD

Twenty-seven male and female outpatients in our lithium clinic who had received this medication for maintenance treatment of bipolar or unipolar manic-depressive illness or schizo-affective illness for periods of 3 months to 5 years were randomly selected from a total population of 105 patients. None of the 105 patients complained of any neurological symptoms except intermittent tremor (1). None of the patients examined were taking any other drugs concomitantly with lithium carbonate. The study population ranged in age from 28 to 75. Neurological examinations were performed at regularly scheduled outpatient visits. Patients were examined for cogwheel rigidity in both arms. In this procedure the examiner moves the patient's forearm while the patient remains passive; the resistance that the examiner encounters is subject to a series of rapid fluctuations that can be shown to be due to the superimposed effect of the tremor's causing an alternating contraction and relaxation of the muscle being stretched (2). Cogwheel rigidity was rated on a severity scale of 0 to 4.

Nine randomly selected patients were given 4 mg of benztropine (Cogentin), injected into the anticubital vein. Each patient was reexamined for cogwheel rigidity after 5, 10, 15, 30, and 60 minutes.

RESULTS

Of the 27 outpatients included in this preliminary study, 6 received lithium for 3 to 8 months, 1 for 11 months, and 20 for 1 to 5 years. The results indicate that no patient receiving the drug for periods of 8 months or less showed any evidence of cogwheel rigidity (see table 1). All but five patients receiving lithium beyond 1 year showed evidence of cogwheeling. This symptom is apparently related to the length of treatment rather than age, sex, lithium dosage or blood levels, or the bipolar-unipolar or schizo-affective nature of the illness; the more severe cogwheel rigidity seemed to occur in those individuals who had received lithium for a long period of time. Compared to the rest of the sample, the cogwheel rigidity was more pronounced, more coarse, and more objectively visible during examination in those patients who had taken lithium for at least 3 years, and these patients more often perceived it as pathology. A 75-year-old woman who had received lithium for 1½ years suffered from cogwheeling rated at 1–2, while a 38-year-old woman who had taken lithium for 5 years had a cogwheel severity rating of 4.

The intravenous administration of benztropine in 9 outpatients with cogwheel rigidity did not result in the disappearance of these symptoms, although 2 patients seemed to improve somewhat (see table 1). This questionable amelioration of symptoms was not related to the variables of age or sex.

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TABLE 1
Cogwheel Rigidity in Patients Receiving Lithium Carbonate

Patient	Age	Sex	Diagnosis	Months of Treatment	Severity of Cogwheel Rigidity*	Effects of Benztropine
1	62	Male	Bipolar	3.5	0	
2	58	Male	Bipolar	6	0	
3	40	Male	Bipolar	8	0	
4	45	Female	Unipolar	5	0	
5	33	Male	Unipolar	3	0	
6	72	Female	Bipolar	6	0	
7	57	Male	Bipolar	11	1	
8	75	Female	Bipolar	18	1–2	None
9	38	Female	Bipolar	60	4	Improvement
10	55	Female	Bipolar	60	1–2	
11	74	Female	Bipolar	48	4	None
12	68	Male	Bipolar	60	0	
13	65	Male	Bipolar	60	0	
14	53	Female	Bipolar	12	0	
15	57	Female	Unipolar	14	1–2	
16	35	Female	Unipolar	36	2	
17	38	Female	Unipolar	60	4	
18	29	Male	Bipolar	13	0	
19	28	Female	Unipolar	16	1–2	None
20	60	Female	Unipolar	36	3	None
21	37	Female	Bipolar	24	1–2	
22	39	Male	Bipolar	30	0	
23	65	Female	Bipolar	36	2–3	None
24	51	Male	Bipolar	48	2–3	Improvement
25	56	Female	Unipolar	48	2	None
26	54	Female	Unipolar	36	3	None
27	45	Male	Schizo-affective	16	1	

*Severity was rated on a scale of 0 to 4.

DISCUSSION

To our knowledge, the occurrence of cogwheel rigidity in patients on short- or long-term lithium therapy has not been previously recorded. Cogwheel rigidity is one of the two recognized varieties of parkinsonian rigidity and represents the most common example of muscular hypertonia due to an extrapyramidal lesion (2). The cogwheel rigidity observed in our patients occurred in the documented absence of other extrapyramidal or neurological symptoms. Benztropine, an antiparkinsonian drug, failed to attenuate or abolish these symptoms significantly.

A fine intermittent essential tremor has been reported with the short- and long-term use of lithium (1). Although it is resistant to antiparkinsonian drugs, the tremor is aggravated by intention, including writing or picking up a cup. It is relieved during sleep. Tardive dyskinesia, or terminal extrapyramidal insufficiency syndrome (3), can result from the long-term use of neuroleptic drugs such as the phenothiazines and butyrophenones; it is largely treatment resistant and is not relieved or ameliorated by the administration of antiparkinsonian drugs (4–7).

Furthermore, whether or not this phenomenon has already been recorded, it has been our experience that although severe extrapyramidal symptoms due to phenothiazine or butyrophenone drugs are often relieved by antiparkinsonian medications such as benztropine, they can nevertheless be accompanied by the persistence of cogwheel rigidity. An extrapyramidal disorder most frequently refractory to antiparkinsonian medication is akathisia (8). Thus the failure of antiparkinsonian drugs to relieve neurological symptoms reflective of involvement of the extrapyramidal system indicates that such drugs cannot always be used as a diagnostic tool in confirming extrapyramidal system involvement.

More careful neurological examination of long-term lithium-treated patients is in order to elicit more discrete neurological lesions that have not been previously sought and that may be present. There is certainly no evidence now that these symptoms are in any way hazardous to any lithium-treated patient; in fact, they are not subjectively apparent. There are no other objective findings of parkinsonism. However, according to our findings, lithium appears to affect the extrapyramidal system after long-term use. This, coupled with the antiparkinsonian-drug-resistant nature of this symptom, requires that patients on long-term maintenance be monitored to verify the absence of extrapyramidal side effects.

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Imipramine and Seizures

BY THEODORE A. PETTI, M.D., AND MAGDA CAMPBELL, M.D.

The authors report the case of a psychotic preschool child who manifested a seizure disorder while on imipramine treatment. They note that according to his history and physical exam, the child fell within a group which seems predisposed to this side effect. Although tricyclic antidepressant compounds can be used judiciously with seizure-prone individuals, the authors recommend that alternative modalities be given first consideration.

THE TRICYCLIC ANTIDEPRESSANT imipramine (Tofranil, Presamine) has been found effective in the treatment of certain behavioral disorders of childhood, e.g., enuresis, hyperactivity, and school phobia. It is anticipated that the indications and use of this group of compounds in the treatment of children will increase (1–3). An earlier paper coauthored by one of us (M.C.) contained a reference to a child who first manifested a seizure disorder during treatment with imipramine (4). Since little mention of this serious side effect has appeared in the literature, we will present a greater elaboration of this case, including follow-up information.

CASE REPORT

The patient, Victor, was 2 years and 10 months old when he was referred for evaluation and treatment by a pediatric neurologist. He was diagnosed as having childhood schizophrenia with autistic features. The parents were primarily concerned with his lack of speech, inability to respond to affection, feeding difficulties, temper tantrums, and negativism. During gestation, his mother took 150 mg of propylthiouracil a day and occasionally took meprobamate (Miltown, Equanil). She experienced sporadic vaginal spotting during the first trimester. Victor was delivered by forceps; his birth weight was 6 pounds, 3 ounces. Development had been deviant and uneven from earliest life, with regression after a moderately febrile course of measles at the age of 15 months. Rare instances of "staring" occurred before admission.

On physical examination, he was a clumsy child walking on his tiptoes; muscle tone was doughy, knee jerks were hypoactive, and he ranked in the 50th percentile in both height and weight. On the Gesell Developmental Schedules he had a motor developmental quotient (DQ) of 62, adaptive of 61, language, 33, and personal-social, 44. Laboratory work-up, including complete blood count, urinalysis, serum glutamic oxaloacetic transaminase, cytogenetic studies, serum glutamic pyruvic transaminase, and skull and chest X rays, showed no abnormalities. An EEG with chloral hydrate premedication was interpreted as normal. At the age of 3 years and 2 months, Victor was started on 25 mg of imipramine a day as a single oral dose in the morning. The dose was increased weekly by 25 mg to a maximum dose of 125 mg a day. The patient showed marked increases in language production, motor initiative, and play throughout the drug regulation. He was initially apathetic, but his affect became more responsive on imipramine. On the 28th day of treatment, while on 125 mg a day, he developed chicken pox and later superimposed impetigo and cervical lymphadenitis. After 1 week, when a possible excess of the drug was suspected, imipramine was stopped.

Imipramine was reinstituted 15 days later at 75 mg a day. The child responded as before with positive therapeutic effects. However, on the second day of treatment he became more irritable and showed less spontaneous behavior; 4 hours after drug administration he developed a grand mal seizure. The drug was discontinued immediately. A second grand mal seizure oc-

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curred the next day. An EEG performed 4 days later was interpreted as normal for chloral-hydrate-induced sleep. The patient was in status epilepticus 10 days after the initial seizure.

Although he was placed on phenobarbital and diphenylhydantoin (Dilantin), grand mal, minor motor, petit mal, and psychomotor seizures continued long after the imipramine was discontinued. Neurological examination, lumbar puncture, numerous EEGs, skull X rays, and other repeat laboratory studies were within normal limits. Whereas Victor's language DQ was 50 and his adaptive DQ was 78 before treatment with imipramine, 2 months after the discontinuation of the drug both language and adaptive DQ rose to 102 on the Gesell Developmental Schedules. A year later at discharge, there was a general behavioral improvement (IQ of 89 on Stanford-Binet) and Victor was seizure-free on anticonvulsants.

Follow-up revealed that 3 years after the initial seizure, Victor was noted to have occasional minor motor seizures; 5½ years later, an EEG was interpreted as abnormal, showing signs of a "centrencephalic seizure disorder with features of petit mal." He continued to have occasional episodes in which he might "go out" for a few seconds. He developed myoclonic seizures of short duration 74 months after the initial seizures and was placed on ethosuximide (Zarontin) in addition to diphenylhydantoin and phenobarbital. Since then he has had some occasional "seizure suspect" episodes but is doing well. He continues to function at a satisfactory level in a structured school setting for the educably retarded.

DISCUSSION

Reports relating to the epileptogenic properties of imipramine include those on both seizure-prone and epileptic adults (5–9) and those on persons with no previous history of susceptibility (9, 10). Also, amitriptyline (Elavil), like other tricyclic compounds, has been associated with the induction of seizures in susceptible adults (11, 12).

In children, occurrence of seizures on imipramine maintenance seems to be related to seizure proneness. Brown and associates (13) reported on 3 hyperactive, aggressive children with organic brain disease and no previous history of seizures. These subjects developed seizures while receiving imipramine in divided dosages of from 150 to 250 mg a day. The 3½-year-old they described had EEGs interpreted as normal for his age and for sedated sleep before and 2 months after the seizures. There was no mention of a prior EEG for the 6-year-old child; the 8-year-old's pretreatment EEG was described as "nonparoxysmal, compatible with some form of cerebral dysfunction."

Kajitani (14) studied 28 retarded children without epilepsy and found that on imipramine there was an increase in spikes in all 4 who had had spike discharges on EEG before medication. Valentine and Maxwell (15) reported on one child (of 16 severely retarded enuretic children) with no previous seizure history who convulsed on 75 mg a day of imipramine. On the other hand, a 9½-year-old enuretic child with a grand mal pattern on pretreatment EEG and status epilepticus of 24 hours duration while on prochlorperazine (Compazine), experienced no seizures while on imipramine (16).

The tricyclic group of compounds has also been reported as having anticonvulsant properties. Rapoport (17), for instance, treated 41 outpatients aged 5 to 21 years with low doses of imipramine. The pretreatment EEGs were abnormal in most cases and "similar to those seen in certain forms of epilepsy." The EEGs showed consistent changes toward normal patterns during the treatment period.

Fromm and associates (18) administered imipramine (in addition to anticonvulsants) to 20 patients, from 3 to 31 years of age, who had petit mal or minor motor seizures. Exacerbation of grand mal and psychomotor seizures occurred in 5 cases, necessitating an increase in the dose of diphenylhydantoin or primidone (Mysoline). Uncontrollable increases in major seizures were never provoked and the decrease in seizure frequency was usually accompanied by a decrease in paroxysmal discharge on EEG. An adult suffering from temporal lobe epilepsy with secondary generalization and a severe psychotic depression was given 100 mg twice a day of desipramine hydrochloride (Norpramin, Pertofrane); both depressive symptoms and the number of seizures decreased (19).

CONCLUSIONS

It is conceivable that our patient was seizure prone due to several factors: he was schizophrenic (20–22) and had a questionable previous history of petit mal. He had the further insult of a viral infection, which may have had some effect on the central nervous system. The reinstatement of imipramine under these conditions at an intermediate single daily dosage rather than at a gradual schedule of divided daily doses (23) could have been a trigger mechanism.

Even though difficulty was encountered in regulating the anticonvulsant medications in this patient, a review of the literature for both adults and children with an epileptic potential suggests that such patients can be maintained on imipramine-like compounds and be relatively seizure free with concomitant use of appropriate anticonvulsants (9, 13, 18, 19, 24). Therefore, when the clinician is presented with such a patient and a tricyclic compound is the treatment of choice, a good assessment of seizure potential, a gradual achievement of therapeutic doses of the drug, and an appropriate anticonvulsant regime should be employed. Since effective compounds unrelated to the tricyclics are available for most disorders, imipramine-like agents should not be the first medication of choice in individuals who have a potential for seizures.

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Electrocardiographic Monitoring of Enuretic Children Receiving Therapeutic Doses of Imipramine

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The authors studied the monthly electrocardiographic tracings of 27 children with normal cardiovascular function receiving imipramine therapy for enuresis. They found no substantial EKG changes in any of these children, who were receiving doses of 25 to 75 mg of the drug. They conclude that electrocardiographic monitoring may be essential only when more than 25 to 75 mg of imipramine is given and that it should be established that the patient's cardiovascular function is normal before the drug is administered.

SINCE MACLEAN'S OBSERVATION of the possibility of its usefulness in 1960 (1), imipramine hydrochloride has been widely used in the therapy of childhood enuresis (2, 3). In 1960 Noack (4) described a case of imipramine poisoning in a pediatric patient. Several reports of toxicity have since appeared (5, 6).

Because imipramine has a direct effect on the myocardium, many of the complications of this drug are cardiotoxic in nature. These disturbances occur with so-called overdoses and include atrioventricular (A-V) dissociation (7), atrial fibrillation (8), ventricular conduction defects (9), alterations of the terminal phase of the QRS-T complex (9), and myocardial infarction (10). The only cardiovascular effect noted thus far with therapeutic doses of imipramine has been postural hypotension and first-degree A-V block (11).

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Kristiansen (12) noted specific electrocardiographic abnormalities in adults receiving therapeutic doses of imipramine hydrochloride for depression. These abnormalities include flattening or inversion of the T waves and, occasionally, depression of the S-T segment. In this paper we will describe the monthly electrocardiographic monitoring of 27 children receiving three dose schedules of imipramine hydrochloride for treatment of enuresis.

METHOD

Twenty-seven children, 18 boys and 9 girls 5 to 12 years old, were included in the study population. All of the children were enuretic at least three times each week for a one-month pretherapy period. There was no preexisting cardiovascular disease in the study population. Blood pressure determinations were taken before therapy was instituted and at each successive monthly visit. All patients admitted to the study had a normal complete blood count, blood urea nitrogen, and urinalysis.

An electrocardiogram was taken on the last day of the pretherapy period. All patients were then given 25 mg of imipramine hydrochloride one hour before bedtime every day. No restrictions were made regarding fluid intake, and parents were asked not to awaken the child in the middle of the night. The children were reevaluated every 30 days. The dose of imipramine was increased to 50 mg if there was less than a 60 percent improvement in the number of dry nights. An increase to 75 mg was made if there was still less than a 60 percent improvement by the third month of therapy.

The dose of imipramine hydrochloride employed in the evaluation varied from 0.7 mg/kg to 2.3 mg/kg given daily one hour before bedtime. An electrocardiogram was taken on the last day of therapy in each 30-day period. The following EKG measurements were evaluated: heart rate, P-R interval, Q-R-S interval, corrected Q-T interval, depression of the S-T segment, T-wave inversion or flattening, and arrhythmias of any kind.

RESULTS

Of the 27 patients in the study, 11 received 25 mg of imipramine for at least two months. The dose given 16 patients was increased to 50 mg. Seven children received 75 mg. There was no evidence of any statistically significant change in any of the EKG measurements monitored at any of these dose levels. Significant improvement was noted in the number of dry nights at each level.

Eleven patients receiving 25 mg of imipramine showed a 60 percent improvement over a two-month period. Nine patients receiving 50 mg of imipramine demonstrated this improvement, and only 3 patients showed less than a 60 percent improvement when the dose was increased to 75 mg. Also important was the subjective observation by parents that on nights when wetting did occur the amount of urine appeared to be less.

DISCUSSION

Electrocardiographic abnormalities associated with imipramine overdose commonly include abnormalities of cardiac conduction, depression of the S-T segment, T-wave changes, and various arrhythmias. The cardiotoxic disturbance may be caused by the anticholinergic properties of imipramine hydrochloride and its direct toxicity to the myocardium.

Imipramine is a substance that blocks norepinephrine activity at adreoreceptor sites so that there are increased levels of norepinephrine available. For this reason, propranolol hydrochloride (Inderal), a β-adrenergic blocking agent, has been used with success in some patients (5, 13). Some authors believe that imipramine's effect is mediated through adenosine triphosphate (ATP)-phosphohydrolase, which is concerned in the active transport of sodium and potassium across cell membranes. There is an exit of potassium from the cell with a final imbalance of the intracellular-extracellular potassium ratio.

Penny (14) made use of this theory by treating imipramine overdose with intravenously administered potassium chloride. Kristiansen (12), in a careful investigation, could not prove that potassium was involved in the cardiotoxic effects of imipramine; he found no correlation between EKG alterations and serum or urine potassium values.

Schou (15) also noted EKG abnormalities in patients receiving large doses of imipramine hydrochloride for depression. These changes were reversed once therapy was discontinued or the dose reduced. Severe toxic effects in children can be produced by doses of 10 to 20 mg/kg of imipramine (16). As little as 75 to 100 mg of imipramine can produce severe symptoms in a child, and 350 mg can prove fatal to a 1½-year-old child (6).

The most frequent type of poisoning occurs when a younger sibling ingests the small, attractively colored medication meant for the older enuretic. Suggestions have been made (17) for decreasing the frequency of toxic overdose. At the dose range used in our study, no side effects that were significant enough to warrant discontinuing the medication were reported. Careful monitoring of many measurements during imipramine therapy has been noted (3); the drug appears to be safe when given in conventional doses.

Since EKG alterations have been induced primarily in elderly patients, especially those with preexisting hypertension or myocardial disease, it is not necessary to monitor EKG changes in children taking low doses of imipramine. Monitoring may be essential, however, if doses above 4 to 5 mg/kg are administered. Particular attention should be directed toward establishing that the patient has normal cardiovascular function before this medication is offered.

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Imipramine and Electrocardiographic Abnormalities in Hyperactive Children

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The authors report seven cases of electrocardiographic abnormalities occurring in 7- to 10-year-old children receiving imipramine pharmacotherapy for behavior disorders. Three of the children evidenced a first-degree atrioventricular block. The abnormalities were less pronounced in the other four children. Imipramine plasma levels during steady state were not found to be directly related to the extent of the electrocardiographic changes within the obtained plasma values. The authors emphasize the necessity of careful clinical surveillance of children receiving imipramine pharmacotherapy.

IMIPRAMINE, a tricyclic antidepressant, is an effective agent frequently employed in the management of enuresis (1, 2) and hyperactive/aggressive behavior (3–6) in pediatric medicine.

Although the drug is generally considered to be safe for pediatric use, a number of side effects have been described (6, 7). These include dryness of the mouth, drowsiness, dizziness, lethargy, tremors, sweating, insomnia, nausea, constipation, and appetite disturbance. More serious toxicity reactions are known to have occurred in association with the therapeutic use of imipramine. For example, Saraf and associates (7) reported the sudden death of a child receiving an unusually large single bedtime dose of 14.7 mg/kg of imipramine. We have noted (8) the occurrence of seizures in previously seizure-free children following the administration of imipramine. Death (9) and near-fatal reactions (10) as the result of accidental imipramine poisoning have also been reported.

Since the clinical effectiveness and potential toxicity of imipramine are functions of the amount of free drug available (i.e., the non-protein-bound fraction), and since protein binding of imipramine is greater in adults than in children (11), it would appear that children are at greater risk for the development of potentially dangerous side effects. This concern led us to obtain electrocardiograms (EKGs) for the pediatric patients involved in our pharmacokinetic studies of imipramine. This paper describes some of our preliminary findings.

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METHOD

The study group consisted of seven children (six boys and one girl) 7 to 10 years old who had been admitted to the Kings County Hospital-Downstate Medical Center for treatment of severe hyperkinetic/aggressive behavior disorders. Each child received a total of 5 mg/kg of imipramine a day, which was administered in three equally divided doses at 7 a.m., 3 p.m., and 11 p.m. Blood specimens were obtained at 9 a.m. on Mondays, Wednesdays, and Fridays until steady state was achieved.[1]

A 12-lead EKG was obtained for all patients before the administration of imipramine and again when steady-state plasma levels were attained (approximately 30 days later). In three patients (numbers 3, 4, and 6) an additional EKG was obtained 30 or more days after the discontinuation of imipramine. At the time of the repeat tracing, patient 3 was receiving 10 mg of methylphenidate twice a day, patient 4 had received 75 mg of chlorpromazine three times a day until 3 days before the examination, and patient 6 had been completely drug free for more than 2 weeks. These medication regimens were necessary for clinical reasons.

All tracings were recorded on a Hewlett-Packard model 1511A direct-writing electrocardiograph machine. On the morning of the EKG procedure, sedation was provided with either 1 to 1.5 g of chloral hydrate or 10 to 30 mg of flurazepam. In our clinical experience neither of these drugs, at the doses prescribed, produces EKG changes. In addition, our search of the literature did not reveal any studies that relate electrocardiographic abnormalities to the use of either chloral hydrate or flurazepam in clinical practice.

RESULTS AND DISCUSSION

The major findings of our study are summarized in table 1. As can be seen, the pretreatment EKGs of all the children were found to be normal. However, imipramine administration produced EKG alterations in all seven children. In each case the repolarization process was affected, as manifested by a decrease in T-wave magnitude and an increase in T-wave width. In addition, patients 3, 4, and 7 developed sufficient increases in P-R interval to indicate a first-degree atrioventricular (A-V) block when corrected for heart rate (12). The Q-R-S interval and the Q-T interval corrected for heart rate (Q-Tc) were not affected by the administration of imipramine. Patient 4 also showed a minor shift of the P and T axes, and patient 5 showed a shift in the P axis to the left.

As can be seen in table 1, the presence of first-degree heart block showed no relationship with steady-state plasma levels of imipramine. This finding is consistent with that of Burrows and associates (13), who found that EKG abnormalities in 20 patients treated with nortriptyline were not associated with steady-state plasma levels of that drug. The EKG changes for patient 3, which are illustrative of many of the findings, are shown in figure 1.

The findings in the three children for whom an EKG was obtained after discontinuation of imipramine therapy are interesting and may reflect their medication status at that time. Patient 3, who was receiving methylphenidate, showed loss of the induced first-degree A-V block and incomplete reversion of the T-wave changes (see figure 1). Patient 4, who was receiving chlorpromazine until three days before the EKG procedure, also showed loss of the first-degree block, although T-wave changes persisted. Finally, patient 6, who was drug free, showed complete return of the T-wave configuration seen before imipramine was administered.

The observed EKG changes noted in this group of children are comparable to those reported for adults receiving imipramine therapy (14, 15). Similar alterations have also been reported in adults receiving therapy with other psychotropic agents such as the phenothiazines, particularly thioridazine (16). We could find only one published report that included EKG findings in its assessment of imipramine pharmacotherapy in a group of behaviorally disordered children (6). In that study no EKG changes were found. However, the low doses employed (an average of 80 mg a day in two divided doses) probably accounts for the lack of effect on the EKG. On the other hand, Koehl and Wenzel (17) reported the case of a 9-year-old girl who developed hypotension after being treated for enuresis with 25 mg of imipramine twice daily. A subsequent EKG for this girl revealed a first-degree A-V block.

Saraf (18) reported having found no EKG abnormalities in a group of children receiving 75 to 150 mg of imipramine a day, with the medication administered, for the most part, in a single nighttime dose. Unfortunately, his EKG tracings were obtained more than 12 hours after the administration of the drug. Since imipramine reaches peak plasma levels approximately 1 to 2 hours after the administration of a single dose (11), one would have expected any EKG manifestations to appear within that time. Support for this likelihood is provided by the work of Kantor and associates (19), who found the appearance of a 2-to-1 A-V conduction block to be associated with the plasma concentration of imipramine.

We think that the EKG abnormalities found in some patients treated with tricyclic compounds must be a consequence of the electrophysiological alterations induced by these drugs. The transmembrane action potential is the electrophysiologic correlate of the surface EKG (20, 21). Thus alterations in transmembrane potentials produced by ionic fluxes are mirrored fairly well in the EKG. One may therefore speculate that since there were no observable changes of significance in the magnitude, shape, duration, or orientation of the P waves in our patients, imipramine prolongs the P-R interval by decreasing the resting membrane potential, consequently decreasing the velocity of depolarization in phase 0 of the transmembrane action potential in the A-V node. Furthermore, since there were no observable changes in the

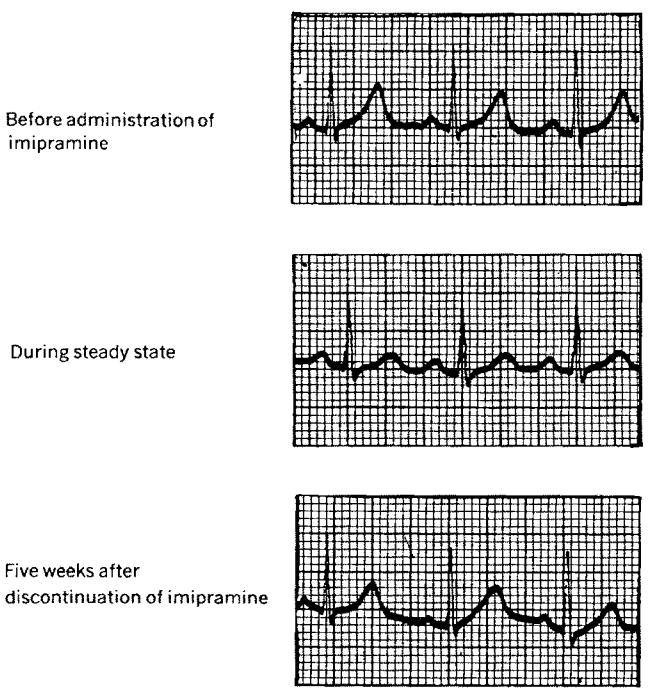
[1]For our purposes, steady state is reached when four out of five successive plasma determinations yield a standard deviation-to-mean ratio that does not exceed ±.05. The actual steady-state value is the mean of the four determinations.

TABLE 1
EKG Changes in Seven Children Receiving Imipramine Therapy

Item	Patients*						
	1	2	3	4	5	6	7
Age	7	8	8	8	7	10	7
Sex	Male	Male	Male	Male	Male	Female	Male
Steady-state plasma level of imipramine (in ng/cc)	140	210	250	250	250	330	440
Total 24-hour dose of imipramine (in mg)	105	105	150	105	150	180	105
EKG tracings before administration of imipramine							
Heart rate	84–110	96–102	86–94	106	67–73	98–102	72–90
P-R interval (in seconds)	.10–.12	.14	.16	.16	.14	.14	.16
P-axis	WAP**	+45°	+60°	+15°	+50°	+60°	+55°
Q-R-S-axis	+60°	+90°	+60°	+60°	+50°	+45°	+65°
T-axis	+60°	+60°	+60°	+45°	+15°	+45°	+50°
EKG tracings during steady state							
Heart rate	145	100	100	101–106	79–80	100	105
P-R interval (in seconds)	.14	.14	.18	.18	.15	.15	.18
P-axis	+60°	+45°	+60°	+35°	0°	+60°	+60°
Q-R-S-axis	+60°	+90°	+60°	+60°	+60°	+45°	+75°
T-axis	+15°	+60°	+60°	+30°	+30°	+45°	+30°

*Patients are numbered in increasing order according to the level of steady-state plasma.
**The tracings indicated a wandering atrial pacemaker.

FIGURE 1
Lead 2 EKG Tracings for Patient 3



Q-R-S or Q-Tc intervals, one can speculate that imipramine produces T-wave changes by slowing the descent of the rapid depolarization slope in phase 3 of the ventricular action potential.

The mechanisms of action whereby these changes take place have not as yet been elucidated. If inferences are to be drawn from published reports on the phenothiazines, the clinical significance of these changes in terms of potential dangers is controversial at present.

Wedkos (16) suggested that these changes are benign in nature and that hypokalemia may be responsible for them. However, Ban and St. Jean (22) could not demonstrate alterations in serum electrolytes to explain the EKG changes. Leestma and Koenig (23) suggested that drug inhibition of magnesium-dependent sodium, potassium adenosine triphosphatase (N, K-ATPase) is responsible for the EKG changes. On the other hand, Richardson and associates (24) demonstrated pathologic alterations of intramyocardial arterioles and of the arteriolar-capillary bed, along with local myocardial destruction in victims of sudden death. These authors held that the physical changes are responsible for the EKG changes. Anatomically, the myocardial lesions were subendocardial along the entire course of the right and left A-V bundle and in the papillary muscles.

Crane (25), in a review of the literature, conceded that the prognostic significance of the EKG alterations could not be answered at that time (1970). The participants in a conference sponsored by the National Institute of Mental Health's Early Clinical Drug Evaluation Unit in May 1974, which was devoted to consideration of the cardiologic complications of psychotropic drugs, could draw no conclusions concerning the causal association between EKG abnormalities and sudden death.

In view of the many unknowns in this area of investigation it would be judicious at the present time to avoid the administration of imipramine to children with significant heart disease, particularly if they are already receiving drugs that affect conduction and repolarization.

Considering the increasing number of young patients receiving imipramine therapy for behavior disorders and enuresis, it would behoove us to investigate in depth the effect of this drug on the following areas: the A-V nodal, His, Purkinje, and ventricular action potentials; the A-V conduction system; the vectorcardiogram; the dynamic

electrocardiogram; and myocardial contractility. We are considering further investigations along these lines. To facilitate replication and evaluation of such research, investigators should report doses in terms of mg/kg, and they should determine the plasma levels of free imipramine in their subjects.

SUMMARY AND CONCLUSIONS

A total dose of 5 mg/kg of imipramine a day in three equally divided doses, administered for the treatment of hyperkinetic/aggressive behavior in 7- to 10-year-old children, produced electrocardiographic changes in all of the seven children studied.

Decreased magnitude and increased width of the T waves were observed in all of the children; these phenomena are thought to reflect slowing of the descending slope of phase 3 of the ventricular action potential. Complete reversion of the T wave to normal was observed in only one of three patients restudied 30 or more days after discontinuation of imipramine therapy. The persistence of abnormalities in the other two patients is seen as most likely a consequence of the medication that they received after imipramine was discontinued.

That phenothiazines can produce EKG changes is clearly documented. It is more difficult to explain the presence of EKG changes in the child who was receiving methylphenidate. In our review of the literature we could not find any report of EKG abnormalities associated with the administration of methylphenidate. This question clearly needs further research.

Prolongation of the P-R interval, which was noted in three children, is believed to reflect decreased resting membrane potential and decreased velocity of depolarization of the transmembrane action potential in the A-V node. The presence of first-degree A-V block in these three subjects was apparently not associated with the steady-state plasma concentrations of imipramine that were obtained in this study.

Considerable investigative work remains to be done in order to elucidate the mechanisms by which imipramine produces electrocardiographic changes in children and to determine the clinical significance of these changes. In the interim, it would be judicious to withhold imipramine administration from young patients with significant heart disease, particularly if they are already receiving medications that may alter conduction and repolarization.

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Imipramine Dosage in Children: A Comment on "Imipramine and Electrocardiographic Abnormalities in Hyperactive Children"

BY THOMAS A. HAYES, M.D., MARTHA LOGAN PANITCH, PH.D., AND EILEEN BARKER, M.B., CH.B., M.P.H.

The authors asked that this paper be published as a comment on the preceding article by Dr. Winsberg and associates, who approved the suggestion.

WINSBERG AND ASSOCIATES' PAPER reports the preliminary results of a study using 5 mg/kg of imipramine a day in seven disturbed children. Electrocardiographic abnormalities were found in all of these patients, one of whom (patient 1) developed a heart rate of 145 beats a minute. Because we have no reason to doubt the accuracy of the dosage records or the interpretation of the EKGs, these findings prompt us to raise the following questions: 1) Can the reported EKG changes be validly related to drug administration? 2) Do these children exhibit a peculiar sensitivity to cardiovascular effects of imipramine? 3) What is the reaction of the Food and Drug Administration (FDA) to these findings?

DRUG ADMINISTRATION AND EKG CHANGES

Cardiovascular changes during imipramine therapy, in cases of overdose, and in animal studies have been well documented. These changes appear as tachycardia, hypotension, T-wave abnormalities, ventricular extrasystoles, and bundle branch block (1, p. 189). In cases of overdose, persistent cardiac arrhythmias and delayed (up to 3 days after the overdose) cardiovascular death (2, 3) are recognized hazards.

Cardiovascular changes are clearly drug induced; therefore, we must examine dosage. The recommended dose of imipramine for enuresis (the only condition for which the drug is approved for children) is about 50 mg a day. This would average 1 to 2 mg/kg a day. For 6-year-olds, the maximum dose would be 2.5 mg/kg a day. However, the reports in the literature attest to the fact that the drug is used clinically in a variety of other conditions and at higher doses. The attendant toxicity may be excessive or even fatal.

Imipramine has been used in doses of 100 to 200 mg (3 to 5 mg/kg) a day in studies of hyperactive behavior disorder (4–7). School phobia has been treated with up to 300 mg (14.7 mg/kg) a day (8), and other behavioral abnormalities have been treated with doses up to 225 mg (10 mg/kg) a day (9). These doses must be considered in perspective. The average acute lethal dose of imipramine for adults is 30 mg/kg (10). Fatalities have been reported at doses as low as 8 mg/kg (11, 12). The dose of 14.7 mg/kg a day used to treat school phobia also resulted in a fatality (8).

Fatalities resulting from overdoses of imipramine should not be our only concern. Steel and associates (13) reported that symptoms of an overdose may be precipitated by the ingestion of 10 mg/kg of imipramine. They reported a case in which drowsiness, tremor, agitation, and tachycardia occurred after ingestion of 6.4 mg/kg of the drug. Because of the possibility of delayed cardiovascular death, one group (14) recommended that an adult who has ingested 200 mg or more of imipramine be considered to have taken an overdose and be treated in a cardiac intensive care unit and with bed rest for 10 days. Depending on weight, this dose would amount to 2 to 5 mg/kg. Children treated with 4, 8, and 10 mg/kg a day have experienced convulsions (9).

In the report of Winsberg and associates in this issue of the *Journal*, 5 mg/kg a day caused tachycardia and heart block of undetermined duration.

In animals there is also some evidence that immaturity is associated with toxicity. Goldenthal (15) reported that 1- and 2-day old rats could be killed with only 30 percent of the adult lethal dose of imipramine hydrochloride measured in mg/kg. In another strain of rats, Goldenthal found that 3 percent of the adult dose of imipramine pamoate caused death in 2-day-old animals. (The pamoate form of imipramine is not approved for any pediatric use.)

In humans, the proportion of the drug that is bound to plasma proteins is lower in children than in adults, suggesting that a much larger proportion of the drug is available to cross the blood-brain barrier (16, p. 425). Although there is a consistent suggestion of a heightened liability to drug toxicity among younger patients, we find nothing to suggest that the children tested in the report of Winsberg and associates were atypically sensitive considering their ages.

FDA'S REACTION

We are concerned that the range of prescribed doses of imipramine has merged with the range of hazardous doses. Reports indicate that heart block, convulsions, and

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death may occur in the absence of signs of adverse effects sufficient to prompt dose reduction. The investigators in the case in which a fatality occurred following imipramine administration for school phobia (8) described their patient as "relatively asymptomatic."

The use of imipramine hydrochloride in children for antidepressant effects or for the purpose of controlling behavior is considered investigational by FDA. Indeed, Winsberg and associates followed appropriate procedures for the investigation of the effects of this drug. However, in light of their findings and the review prompted by them, FDA must revise its estimate of safe dosage of imipramine for investigational use in children.

Martin and Zaug (17, 18) found no EKG changes in enuretic patients receiving 1 to 2 mg/kg of imipramine. Rapoport and associates (4) also found no EKG abnormalities in children with hyperkinetic behavior disorder treated with up to 3.3 mg/kg a day. While these doses appear safe, adverse physical signs should be suspected to be drug induced and dose related.

NEW GUIDELINES

We believe that imipramine may be found to have more uses in pediatric practice than are presently approved and described in the labeling. We would expect to receive further requests for investigational use of the drug. However, we plan to approve investigational protocols for imipramine hydrochloride only when the total daily dose does not exceed 90 mg for a 40-lb child, 110 mg for a 50-lb child, 135 mg for a 60-lb child, 160 mg for a 70-lb child, and 180 mg for an 80-lb child. Furthermore, because of the findings of Winsberg and associates and because of the unreliable occurrence of other warning side effects, we will recommend regular EKG monitoring when doses approach these limits.

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Allergic Conjunctivitis Due to Diazepam

BY ELMAR G. LUTZ, M.D.

The author reports on four patients, all women, who developed conjunctival hypersensitivity during diazepam treatment. This hypersensitivity is self-limited after diazepam treatment is discontinued. The author suggests that conjunctival hypersensitivity could be mistakenly attributed to contact lens irritation rather than to diazepam.

HYPERSENSITIVITY REACTIONS to benzodiazepines are virtually unknown (1). This fact, in addition to their clinical effectiveness and their extreme safety (successful suicides with benzodiazepines are rare), may account for the widespread use of benzodiazepines, especially diazepam (Valium).

It has been my experience that there is a hypersensitivity reaction fairly specific for diazepam. During the past three years, four women (aged 23, 38, 47, and 52) with allergic conjunctivitis came to my attention during the course of psychiatric treatment. All reported marked conjunctival burning, smarting, and foreign body sensations within 1/2 hour after intake of 5 to 10 mg of diazepam. In addition, three of these women reported associated light sensitivity. Interestingly, there were no complaints of itching. Examination revealed marked conjunctival injection. The discomfort seemed to have a peak duration of 4 hours, subsiding gradually within 24 to 48 hours following a single 5- or 10-mg oral test dose of diazepam and coinciding approximately with the plasma half-time of elimination (21 to 37 hours) of diazepam and its primary metabolites, oxazepam and desmethyldiazepam (2). (Diazepam and its metabolites can be detected in the human body up to 7 days following a single dose.)

All four patients using 5 to 10 mg of diazepam one to three times daily had continuous conjunctivitis during diazepam treatment before the connection with diazepam was discovered. I eliminated other possible causes, including sensitivity to eye make-up and cigarette smoke. Repeated single-dose provocation in each instance led to a predictable recurrence of conjunctival vascular engorgement. One woman had an existing allergic diathesis to grass and to tree pollen; she was also hypersensitive to penicillin. None of the women displayed associated skin or systemic allergic effects.

Because of my limited experience, I cannot hypothesize about possible cross-sensitivity to other benzodiazepines. Clorazepate dipotassium (Tranxene) in one woman did not cause any conjunctival irritation. It is possible that conjunctival hypersensitivity is specific for diazepam; sensitization to diazepam seems to have occurred rapidly in all these patients.

Although not previously reported, conjunctival hypersensitivity to diazepam may be quite common. This reaction can be annoying and socially embarrassing—all four women ingested diazepam before social engagements until the causative relationship was recognized. If a person who wore contact lenses developed conjunctival hypersensitivity to diazepam, he might be erroneously diagnosed as having conjunctival irritation caused by the contact lens.

This specific hypersensitivity is self-limited after diazepam treatment is discontinued. The subjective discomfort can be alleviated by the use of tetrahydrozoline hydrochloride (Visine) eyedrops.

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BRIEF COMMUNICATIONS

The Impact of the Psychiatric Intensive Care Unit on Patients and Staff

BY MAJ. HAROLD ROSEN, MC, USAF

Inpatient crisis intervention units have many of the characteristics of medical/surgical intensive care units. The author believes that the environment of these psychiatric intensive care units serves as an important source of stress and may increase the patient's symptomatology and impair the therapeutic effectiveness of the staff. He suggests some modifications in the environment that may ameliorate these effects.

THE INCREASING ACCEPTANCE of crisis intervention as an effective therapeutic modality in inpatient settings has necessitated the development of a therapeutic environment in which the work of crisis therapy can be carried out. Although contributions to this development from such diverse fields as military and community psychiatry have been used (1, 2), an important aspect of this environment which has received little attention as a potential source for further development has been its similarity to the therapeutic environment of the medical/surgical intensive care unit.[1]

As described in the literature (2–7), crisis intervention units and intensive care units share many basic characteristics. Both units are small, highly staffed, and structured to intervene rapidly in acute, severe illness. The multidisciplinary staff is often young, is highly motivated, and functions in a team approach with much of the treatment responsibility shared by nonphysicians. With as many as 50 percent of the patients admitted to crisis intervention units having strongly considered or attempted life-threatening behavior, both units must confront life-endangering illness, and staff members may be called upon to make life-or-death decisions (5, 7, 8).

The duration of treatment is brief, usually measured in days, and is characterized by intense patient-staff involvement and the use of multiple, sophisticated therapeutic techniques. The treatment approach focuses on the presenting problem and emphasizes the importance of providing intensive care at critical points in the illness in order to prevent further morbidity and deterioration of function (1, 2, 7). Cures are often impossible, but whenever possible regression, despair, and hopelessness in response to the illness are discouraged, and an attempt is made to maintain the individual's view of himself as a participant in the process of recovery. In this context, appropriate disposition and follow-up care assume critical importance and frequently require rapid assessment and mobilization of family and community resources (9).

These similarities suggest that the crisis intervention unit may be considered a psychiatric intensive care unit (10,11), and they raise the possibility that the experience gained from psychiatric involvement in intensive care units might be used in crisis intervention settings. One important finding that seems to require such consideration is the role of the intensive care environment as an important source of stress for both patients and staff (12–18). Yet despite the emphasis that crisis intervention theory places on the role of environmental factors in both the etiology and treatment of psychiatric illness, a review of the literature reveals that the potential impact of an intensive care environment in the psychiatric setting has received little consideration (1–7).

This paper will briefly review some of the observations made concerning the impact of the intensive care environment and attempt to apply these findings to the psychiatric intensive care setting.

[1]In this paper the term "intensive care unit" will be used in its generic sense and is meant to include the more recently developed special care units.

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IMPACT OF THE ENVIRONMENT ON THE PATIENT

The Intensive Care Unit

The intensive care environment provides the patient with a sense of security and concern that can enhance the process of recovery (12). However, this environment may also interact with the presenting illness to produce such adverse effects as increased morbidity, retarded recovery, and severe psychological stress (12–17). In the context of severe illness, the environment, with its continuous activity and pervasive sense of disaster, may be perceived as hostile and frightening (9). Already impaired by medications and the underlying illness, the patient's reality testing may further deteriorate under the impact of anxiety, variations in sensory input, sleep deprivation, and the disappearance of diurnal variation (12–17). As the patient's confusion mounts, symptoms of an acute delirium may appear and may progress from mild disorientation to a fulminant psychotic state with hallucinations and delusions (14–15).

The Psychiatric Intensive Care Unit

In a similar fashion, the frightened and confused psychiatric patient is suddenly thrust into an unfamiliar environment characterized by incessant activity, high stimulus input, and a relatively unstructured social organization (5–7). Almost immediately upon his arrival, the patient must begin the task of resolving his difficulties, and the sense of time pressure is constant (3). Interpersonal involvement is encouraged, but when confronted by an often hostile family and a rapidly changing group of distressed strangers, the patient may view the need to disclose intimate details of his behavior as being as unnatural as seeing one's heartbeat on an oscilloscope. The sound of another's anguish may seem as alien as intravenous feeding. Encouraged to participate in the resolution of his problems, the patient feels powerless to modify the immediate source of his distress, and his feelings of anxiety, guilt, and helplessness increase.

Yet the patient may not spontaneously voice his complaints about the environment (12). He is grateful to the staff for their help and fearful of jeopardizing his care, and his developing anger finds expression in conflicts with other patients, negativism, and demands for discharge. As these maladaptive defenses and behaviors are challenged, the patient's affects become intensified; the outcome may be an increase in symptomatology and, for the schizophrenic patient, increased disorganization (6, 19). The additional stress generated by the environment thus further disrupts the patient's ability to participate in the therapeutic task, and the final result may be failure of the therapeutic intervention.

IMPACT OF THE ENVIRONMENT ON THE STAFF

The Intensive Care Unit

Although inpatient crisis therapy is demanding work in which the psychological well-being of the staff is crucial to the success of the treatment method (5), only brief mention has been made in the literature of the nature of the stresses experienced by such clinicians (2). Studies of staff responses to work in intensive care units have revealed that a sense of accomplishment and group cohesion is often counterbalanced by the constant level of anxiety and isolation that results from the need to respond rapidly to complex, life-threatening situations. Like the patient, the staff is exposed to multiple distressing stimuli with few outlets available for frustration and anger. Interpersonal involvement is intense despite the brief period of contact between staff and patient; but each discharged patient is replaced by yet another who requires renewed investment, and the staff must continually confront the pain of involvement and loss (9, 18).

To protect against these distressing affects, the staff employs such defenses as depersonalization, denial, and avoidance, and the patient is dehumanized (9). The temporary relief provided by these defenses permits the restoration of depleted emotional resources and facilitates subsequent reinvolvement. If these defenses are unsuccessful, however, a state of fatigue may ensue that has been compared to combat exhaustion; if it is not overcome, flight, in the form of illness or resignation, may be the outcome (9).

The Psychiatric Intensive Care Unit

Constant involvement with emotional suffering creates similar stresses for the staff of the psychiatric intensive care unit, but the intense interpersonal involvement demanded by crisis intervention makes the use of depersonalization, denial, and avoidance far more difficult if the treatment is to succeed. The responsibility for treatment cannot be shifted to mechanical devices, and the clinician, often with little time available for reflection, is repeatedly exposed to stimuli in the thoughts and actions of his patients that threaten to reevoke his own unresolved conflicts and arouse unacceptable sexual and aggressive impulses.

In this emotionally charged atmosphere, the recurring losses become a major source of stress for the staff. The time-limited nature of the therapy frequently permits only partial resolution of the patient's presenting problem, and the evidence of accomplishment necessary to balance the pain of loss is often lacking. The clinician, who is not supported by a well-defined hierarchy of roles and tasks that could aid in providing him with a sense of purpose and identity, is caught between the conflicting needs of the referral source and the subsequent treatment facility. He discovers that his treatment plan has been changed and the adequacy of his intervention questioned. As a result, he becomes increasingly uncertain of his effectiveness. Persistent feelings of guilt and failure emerge, and in response to them he may attempt to prolong the patient's stay in hopes of effecting a "cure" and may insist on personal follow-up, which is far beyond his and the unit's capabilities.

In addition, the clinician often finds that the structure of the unit provides little opportunity for the direct expression of his growing anger and frustration, and the

highly specialized nature of the work makes it difficult for those not directly involved in the experience to comprehend and accept the intense emotions it engenders. Other staff members, who are struggling with their own responses, may display a diminishing tolerance for the difficulties of a peer, and as a result, relationships inside and outside the unit become strained and contribute further stress. As the clinician attempts to maintain internal cohesiveness, withdrawal and self-involvement increase and his ability to respond to the patient with concern and empathy diminishes. Feeling pulled in opposite directions by his own needs and those of the patient, he begins to feel fatigued and overwhelmed.

Concentration becomes difficult, feelings of impatience and boredom become manifest, objectivity is lost, and the work of therapy becomes an onerous task. The final outcome is a disabling state of exhaustion and emotional depletion that may result in the failure of the therapeutic intervention and increased feelings of guilt and frustration. A destructive, self-perpetuating cycle is initiated that may be broken only by the clinician's resignation from the unit.

This state of exhaustion may also be reached by the entire staff. Once they are caught up in this cycle, self-scrutiny becomes difficult and dissension may severely impair group cohesion. The staff become more distant and emotionally unavailable, and errors begin to accumulate. They may increasingly rely on medications or outside agencies and postpone decisions or make them hastily. If this situation is not identified and corrected, the therapeutic effectiveness of the unit deteriorates until the well-being of the patient is seriously threatened or staff members are lost.

CONCLUSIONS AND RECOMMENDATIONS

The intensive care environment of the crisis intervention unit provides a setting in which the work of crisis therapy can occur. The same environment may, however, serve as a disabling source of stress for both patients and staff, which contributes to the failure of the therapeutic intervention. Yet experience in intensive care units indicates that these stresses can be ameliorated or even prevented and the unit's therapeutic effectiveness maintained (9, 12, 13).

The first, and most important, change that must take place is the staff's increased awareness that such adverse effects do occur so that open discussion of the patient's responses is encouraged and the sources of stress are identified and diminished. As the staff develops a greater understanding of the impact of the environment, the responses of each patient no longer become a source of bewilderment and can be used to further the understanding of his present dilemma.

Whenever possible, the patient should be informed of the nature of the unit and its procedures in order to minimize his initial anxiety and alienation (13). Careful attention must be given to staff selection and training, with special emphasis on willingness and ability to tolerate high levels of stress (2, 9). The senior staff must provide a forum in which the entire staff can discuss their own responses and be willing to provide each other with the necessary emotional support. Group cohesiveness must be maintained (9) and the flow of patients and amount of follow-up care closely regulated in order to prevent the staff from becoming overwhelmed. Finally, the presence at rounds or staff meetings of a senior consultant who is familiar with crisis intervention but not directly involved with the unit may help stimulate self-scrutiny on the part of the staff and prevent the destructive effects of staff exhaustion.

Although a more exact understanding of the impact of the intensive care environment in psychiatric settings must await further study, there seems to be little doubt that the experience gained in intensive care units can and must be used to maximize the therapeutic effectiveness of acute psychiatric inpatient care.

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Depression in Thyrotoxicosis

BY JOHN W. TAYLOR, M.B.

The author describes the case of a middle-aged man who was admitted twice to a psychiatric hospital with depression. On the second admission, his mental state improved following treatment for thyrotoxicosis. The author emphasizes the importance of recognizing such atypical presentations of thyrotoxicosis and postulates a possible depression-producing mechanism in predisposed individuals.

PSYCHOLOGICAL DISTURBANCES have long been considered a common accompaniment of hyperthyroidism and are generally mentioned as such in textbooks of internal medicine and psychiatry (1, 2).

The psychological changes may resemble anxiety states (3), neurasthenia (4), impaired intellectual functioning (5), acute confusional states (6–8), schizophrenia —often with paranoid features—or manic depressive psychosis (9). In addition, other reports of "apathetic thyrotoxicosis" have described prominent psychological abnormalities, especially withdrawal and depression, in thyrotoxic patients (10–13).

Some authors (5, 14) have stated that serious psychiatric disorder is uncommon in thyrotoxicosis, despite the extensive literature on the subject. The difficulties in diagnosing thyrotoxicosis in a patient who presents with what seems to be a psychiatric syndrome and the consequent delay in starting appropriate treatment justify restating the point that severe psychological symptoms may be the first manifestation of this disease.

CASE REPORT

Mr. A, a 51-year-old unmarried bookkeeper, was observed by his brother over a period of 6 months to be quieter, tired looking, and preoccupied. Mr. A complained of inability to concentrate, difficulty sleeping, and constipation. On one occasion, he left home, spent several hours in a nearby park, and then went to a stranger's house and said he was dying. His general practitioner than arranged his admission to the psychiatric hospital. On admission, the patient said he had venereal disease and had killed many people through it. He was worried about masturbation and was thinking of suicide. Glycosuria was also noted. His sister had recently been given electroconvulsive therapy (ECT) for depression. All of his symptoms remitted after treatment with ECT and amitriptyline and he was apparently well for 4 years.

Five years after this illness, Mr. A complained to his general practitioner of the gradual development over 12 months of feelings of depression, anxiety, poor concentration, fears related to masturbation (which he called "the unforgivable sin"), difficulty sleeping, weight loss, and hand tremor. When no improvement was apparent after 3 days of treatment with 50 mg of amitriptyline taken nightly, the patient was again referred to the psychiatric hospital. He was cooperative on admission. At this time he showed psychomotor retardation, anxiety, and depression, and was preoccupied with ideas of guilt, unworthiness, and suicide. His attention span and ability to concentrate were reduced, but he was oriented. He was given 150 mg of amitriptyline daily. Over the next 2 days, he became agitated, disorientated, complained of "bad thoughts," had ideas of suicide, and was increasingly withdrawn. Four days after admission, his temperature had risen to 39 C and his pulse to 150 per minute.

The following laboratory studies had normal results: hemoglobin, total and differential white cell count, blood film, cultures of sputum, urine, throat swab, cerebrospinal fluid, and blood, skull X ray, serological tests for syphilis, liver function tests, and serum electrolytes. The erythrocyte sedimentation rate was 55 mm per hour, blood glucose was 396 mg/100 ml, glycosuria was present, blood urea nitrogen (BUN) was 36 mg/100 ml, a chest X ray showed calcified hilar lymph nodes, and 3,5,3′-triiodothyronine (T_3) resin uptake was 149 percent of standard (definitely thyrotoxic for the testing laboratory), although protein-bound iodine (PBI) was not elevated.

Antibiotics were commenced on the 5th day after admission without apparent benefit. On the 13th day, when the T_3 resin uptake was reported, a regimen was started of 20 mg of propranolol four times a day and 30 mg of carbimazole three times a day, followed promptly by a decline in pulse rate from about 150 per minute to about 100 per minute and temperature from 38 C to normal. After 4 days the patient looked and reportedly felt much better and was more cheerful and well oriented. Subsequently he gained weight, lost his guilty preoccupation with masturbation and other psychological symptoms, and was able to return to work.

After clinical improvement, the patient's BUN fell to 24 mg/100 ml, the serum creatinine was 0.9 mg/100 ml, and blood glucose was normal, as was an oral glucose tolerance test. ^{131}I uptake failed to suppress with T_3 administration and a thyroid scan showed a retrosternal goiter. Propranolol was discontinued without effect after some weeks, but withdrawal of carbimazole 15 months later was promptly followed by malaise and weight loss, so treatment was resumed. A subtotal thyroidectomy was performed 8 months later. At the last follow-up, 18 months after surgery, the patient was doing very well with no antithyroid medication.

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DISCUSSION

Mr. A did not exhibit some of the typical features of thyrotoxicosis like goiter and eye signs, and his PBI was just within normal limits. This is similar to the picture of "apathetic thyrotoxicosis" described by Thomas and associates (13).

During the first episode, glycosuria was present and was presumed to be related to depression, but it could have been a manifestation of thyrotoxicosis. Remission of thyrotoxicosis rather than treatment with ECT and amitriptyline may have been responsible for his improvement. In the second episode, agitated depression was followed by an acute confusional state, during which a depressed mood was still evident. It seems very likely that the mental symptoms present on the latter occasion were due to thyrotoxicosis, as they responded rapidly to antithyroid but not to other medication, and the patient remained well on antithyroid treatment alone.

Whatever the nature of the relationship between the patient's mental state and his thyroid disorder, he presented with an unremarkable psychiatric condition, but became worse when apparently appropriate psychotropic drugs were administered. However, he improved when antithyroid drugs were given. These points are particularly noteworthy because recent publications have minimized the psychological disturbances of thyrotoxicosis and emphasized the less conspicuous intellectual impairment and more frequent occurrence of psychiatric symptoms in hypothyroidism (14). It may be that the depression reported by some authors to precede the clinical onset of thyrotoxicosis (15, 16) is the first sign of the disease itself, rather than a cause.

Gibson (4) quoted various sources who claim that catecholamines are involved in the psychological disorder of thyrotoxicosis, but it is not clear that there is either an increased sensitivity to or availability of catecholamines in thyrotoxicosis (17). The occurrence of depression seems paradoxical in view of the reported effectiveness of thyroid hormones as an adjunct to the treatment of depression (18, 19), but certain reports of the antidepressant effect of thyrotropin-releasing hormone (TRH) suggest a possible mechanism (20, 21). Depression with thyrotoxicosis may result from diminished TRH release due to overproduction of thyroid hormones by the diseased gland. Not all thyrotoxics are depressed, however. Therefore, even if this mechanism is operating, some additional factor or factors must be present—possibly a genetic predisposition to depression.

The occurrence of depression in thyrotoxicosis tends to support the suggestion of Kastin and associates (20) that the mood-elevating effect of TRH is not mediated by thyrotropin or thyroid hormones, but rather by a direct effect of the TRH tripeptide on mood-influencing brain structures. Enhancement of tricyclic antidepressants by L-triiodothyronine probably occurs by a separate mechanism.

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Suicide Attempted by Self-Immolation

BY NANCY C. ANDREASEN, M.D., PH.D., AND RUSSELL NOYES, JR., M.D.

The authors found that 14 individuals who had attempted suicide by self-immolation all had psychiatric illness (most were psychotic), and many had religious preoccupations. There was a reversal of the usual male to female ratios for burn injury and for successful suicide—all 5 completed suicides were women. Although self-immolation as social protest was widely publicized during the years surveyed, the authors note that these individuals all attempted suicide for personal and irrational rather than morally idealistic reasons.

SETTING FIRE TO oneself would seem to be one of the most violent and certain ways to attempt suicide. A fire set to clothing is difficult to arrest, and its effects are irrevocable. Burn injuries are painful, mutilating, and, when they involve large areas, often fatal. Furthermore, fire carries symbolic overtones of psychological interest (1). Martyrs such as Jeanne d'Arc and the Buddhist monks of recent times have dramatized their cause through fiery death. In Western civilization, influenced by the Judeo-Christian tradition, death by fire evokes both the association of torment in the eternal fires of hell and the notion of purification by the holy fires of redemption. The gift Prometheus stole from the gods has been a mixed blessing to man. While it has provided warmth, heat, and light, it has also brought the terrible destruction of fire-bombing, forest fires, and napalm.

Suicide attempts by self-immolation have usually been considered quite rare. A survey of such attempts during the last 10 years based on reports in the *New York Times* yielded only 26 cases in the United States, most of which represented protests against the war in Viet Nam (2). Isolated case reports of suicide by self-immolation have also appeared (3, 4), but no systematic study has been made of this method of self-destruction. In the course of studying all patients admitted to the University of Iowa Burn Unit over a 15-month period, we observed that while this method of attempting suicide was uncommon, it was not rare. In addition, we noted that most patients who burned themselves suffered from psychiatric illness. Accordingly, we undertook the present investigation to examine the situational and diagnostic precursors of attempted self-immolation.

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METHOD

A record search was made to identify all patients admitted to the University of Iowa hospitals and clinics with the joint diagnoses of burn injury and suicide attempt during the past 8 years. This search yielded a total of 14 subjects, 5 of whom died as a result of their injury. The surviving subjects were sent a letter inquiring about their suicide attempt. Whenever possible, they were interviewed directly about their history, the circumstances leading to their attempt, and their state of mind at the time. Of the 5 subjects interviewed personally, 2 later died as a result of their injury. A sixth subject wrote a lengthy letter in answer to our questions. We were able to obtain psychiatric records and follow-up information on 12 of the 14 patients. The Burn Unit records of the remaining 2 patients yielded limited information. We reviewed all records independently and a consensus diagnosis was established using the criteria of *DSM-II* (5).

RESULTS

The subjects were 10 women and 4 men ranging in age from 16 to 75, with a mean age of 42. The body area involved by burn ranged from 4 percent to 95 percent, with a mean of 40 percent. All 5 successful suicides were women.

Diagnoses covered a broad spectrum: schizophrenia, N=4; psychotic organic brain syndrome (secondary to porphyria and brain tumor), N=2; depression, N=2; antisocial personality, N=2; alcoholism, N=2; and mental retardation, N=1. The remaining patient had had a prior psychiatric hospitalization, but no diagnosis could be made as these records were unobtainable.

A majority of the subjects suffered from disturbed thought processes and impaired judgment at the time of their attempt—9 were psychotic and 2 were intoxicated. No information was available on the 3 other patients. Religiosity was a frequent theme as they discussed their attempts. Some felt that they deserved punishment for their sins or that God had abandoned them, while one acted upon the instructions of a hallucinatory voice interpreted as coming from the Divinity. Ten described strong religious backgrounds; 5 of these were Catholic and 5 Protestant. None of the subjects burned him/herself as a form of social protest; all did so for purely personal reasons, primarily psychotic ones.

A substantial number of these individuals were institutionalized at the time of their injury—4 were in penal facilities and 4 were in psychiatric facilities. Six subjects

were at home. Self-immolation did not represent an attempt to gain release from the penal institution for the incarcerated subjects. Two of them were psychotic and a third was intoxicated at the time of injury. For some of those in institutions, fire appeared to have been selected as a method of self-injury because matches were more readily available than other materials. Three of the successful suicides occurred at home and 2 in institutions.

Each of these subjects had a unique history. The following case reports were selected because they reflect the variety of diagnoses, situations, and motivations observed in these individuals.

Case Reports

Case 1. This 75-year-old woman first suffered depressive symptoms at the age of 66. Her first episode was treated with electroconvulsive therapy, which apparently induced a remission lasting until age 70, when symptoms recurred but responded to antidepressant medication. A third episode began at age 75, 3 months prior to her suicide. Symptoms at this time included initial and terminal sleep disturbance, agitation, suspicions that someone was taking her money, somatic delusions, decreased appetite accompanied by delusional beliefs that her food was poisoned or that she was being tormented in hell, crying spells, and feelings of hopelessness. She was fully oriented, showed some recent memory impairment, and had a normal EEG. She showed little response to antidepressant medication during this episode. Three weeks after this medication was discontinued and she was discharged to the care of her husband, she set fire to her dress, sustained 58 percent total body surface burns, and died within 4 days. Before her attempt, she had firmly stated that she would not commit suicide because it was a sin for which God would punish her. During the 4 days of hospitalization prior to her death, she admitted that she had intentionally set fire to herself in order to end her life.

Case 2. At the time of her injury, this 45-year-old housewife had a 10-year history of psychiatric illness, which had been consistently diagnosed as paranoid schizophrenia. Her symptoms included auditory hallucinations, religious delusions, ideas of reference, and feelings of passivity. She was a devout Roman Catholic, and her religiosity increased prior to her self-immolation. At church, she felt that the priest had "singled her out" and had made reference to her in his sermons. She set herself on fire in response to a voice from God telling her to do so. She sustained 35 percent burns but survived. Retrospectively, she denied that setting herself on fire represented a suicidal act, which was against her religion. On the other hand, she recalled hearing voices telling her to take her life by driving her car off a road. She remained psychotic throughout most of her hospitalization on the Burn Unit and was felt to be a significant suicidal risk.

Case 3. A 27-year-old inmate at a men's reformatory had been incarcerated for writing bad checks. He set fire to himself while in isolation and sustained 30 percent burns, which he survived. He had made 10 previous suicide attempts, including 5 unsuccessful attempts at self-immolation. Reformatory authorities indicated that he had been anxious and fearful, threatening self-mutilation if he were not protected from "others," and frequently approached staff members begging to be saved from poisoning or homosexual assaults. When his demands were not met immediately, he would threaten or attempt to injure himself. He described himself as feeling lonely and rejected. Despite attempts to provide psychiatric help for him, he felt "beaten down" and unable to deal with his problems. He became involved in drugs while in prison and was caught; he was punished by being put in isolation. He described his feelings then as follows: "I had lost every friend I had ever had and stood up and set my clothes on fire to die." Following his recovery from burn injuries, he remained in penal facilities for the next 8 years. Symptoms of depression and traits of an emotionally unstable personality were noted in his record, but the final diagnosis was antisocial personality.

Case 4. A 23-year-old woman was brought to the Burn Unit after she had set her dress on fire while in the seclusion room of a state psychiatric hospital. Psychiatric symptoms had first been noticed at age 15 when she was hospitalized for an acute psychosis. Her symptoms, which recurred episodically, included depressed mood, ideas of reference, paranoid delusions, auditory hallucinations, and suicidal thoughts. She also complained intermittently of nervousness, crying spells, and pain in her abdomen. At the age of 19 she was discovered to have elevated urinary porphyrins, and it was concluded that her intermittent psychotic episodes were due to porphyria. She continued to suffer from episodic symptoms and repeatedly made bizarre suicide attempts, which included overdosing, swallowing pins, and mutilating her skin. Her self-immolation, which led to 50 percent total body surface burns that were eventually fatal, occurred during one of these psychotic episodes. She remained alive for about a month on the Burn Unit, during which time she experienced recurrent nightmares that she was on fire again, screaming with terror while people stood by unable to rescue her. She verbalized the wish that she had succeeded in her suicide attempt and admitted to guilt feelings, depression, self-condemnation, and recurrent suicidal thoughts. At times she became violent and agitated, screaming profanities at nurses and on one occasion throwing a coke bottle at a burned child.

Case 5. This 25-year-old man, who sustained 35 percent burns by pouring kerosene on his torso and igniting it after he had been drinking heavily, was attempting to resolve marital problems and dramatize his love for his wife. This was his fourth suicide attempt. He had previously cut his wrists, jumped from a moving car, and tried to hang himself. He had a long-standing history of immature and manipulative behavior and a 7- to 8-year history of excessive drinking. He had been hospitalized for treatment of alcoholism 2 years previously, had been jailed for intoxication, and had lost his driver's license be-

cause of operating a motor vehicle while intoxicated. The patient displayed considerable ambivalence about his unsuccessful attempt. On the one hand, he indicated that he hoped his wife would now realize how much he loved her and that he did not consider life worth living if she did not return to him. On the other hand, he sometimes felt ashamed of himself and indicated that he probably would not have attempted suicide if he had not been drinking excessively. He eventually recovered fully from his injuries.

DISCUSSION

One might suspect that people who choose fire as a method of self-injury would represent a homogeneous group. In fact, these individuals were quite different in motivation, diagnosis, and the circumstances surrounding their injury. The one trait most of them shared was severe psychopathology, secondary either to a psychotic process or to intoxication. A tendency toward violent and bizarre behavior also runs through their records. Although some had attempted self-injury previously, most seem to have had only a vague understanding of the nature and quality of their acts and to have acted impulsively and unpredictably.

The small number of successful suicides is somewhat surprising. Fire would seem to be a relatively certain method of self-destruction, but only 5 of these 14 individuals succeeded in killing themselves. There are several possible explanations for this surprising result. First, 8 subjects were in institutions and therefore were discovered before the flames had progressed very far. None of those in institutions had easy access to gasoline, which would make death more likely. Second, most suffered from impaired judgment and were therefore unable to plan carefully a way to incinerate their entire bodies rapidly and produce death. In fact, many were so impaired that they were not precisely sure about their purpose—whether it was self-injury, self-destruction, self-punishment, or a command from God. Third, treatment of burn injuries has become quite sophisticated during the past 10 years, and many patients who might previously have died are now saved. Five subjects who had significant injuries—from 30 to 55 percent of the body surface—survived because of vigorous medical intervention.

Reasons for selecting fire as a method of self-injury tended to vary almost as much as the diagnoses. As previously mentioned, fire was more readily available than other means for those in institutions, particularly for those prone to act impulsively. Although the Buddhist monks of Viet Nam were in the news frequently during the years surveyed, none of the subjects made any reference to them, although a few may have selected burning as a means to further dramatize their distress. Some were concerned with the religious and symbolic overtones of fire and its painful and mutilating effects. Some could give no reason at all for their use of fire, even though other methods were available. In these cases, one can only say the self-immolation was a reflection of their irrational state of mind.

This investigation uncovered some interesting epidemiological data. Of the approximately 100 patients admitted to the University of Iowa Burn Unit each year, 2 suffered from self-inflicted injuries. The male:female ratio of approximately 2:1 among burn patients was reversed among self-immolators: 10 females suffered self-inflicted burn injuries, as compared to 4 males. Furthermore, although the incidence of successful suicides is much higher among men in the general population, all the successful suicides in this series were female. Although the records were examined for clues as to why suicide by self-immolation might be more common in women, no acceptable explanations were found, and this curious finding remains unexplained.

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An Investigation of Calendar Calculating by an Idiot Savant

BY A. LEWIS HILL, PH.D.

Three mechanisms (eidetic imagery, high-speed calculation, and substitute compensation for normal learning) were investigated and rejected as possible explanations for the calendar-calculating ability of a particular idiot savant. Reaction times for calendar calculations indicated that he used neither an idiosyncratic nor a calendar-based system. Rote memory and a special ability to concentrate for extended periods of time were postulated to explain this individual's performance.

AN IDIOT SAVANT is an individual of low general intelligence who possesses one or more highly developed skills. Probably the most well-known of these skills is calendar calculating, the determination of the day of the week on which a particular date has fallen or will fall. Although there is a mathematical formula for this determination, it is very doubtful that idiots savants use this method. Horwitz and associates (1) suggested three mechanisms as possible explanations for this ability.

The first of these, eidetic imagery, is especially attractive because it offers an explanation that does not require any mathematical ability. The second hypothesis is that these individuals may be able to calculate at great speeds. Of course, this is not an explanation at all, and most idiot savants are very poor at even simple addition and subtraction. The third possible mechanism is that "the skill represents a mechanism utilizing memory and serving as a substitute compensation for normal learning" (p. 1075). It is not clear whether "substitute compensation" implies a normal learning ability which is focused to the extent that the savant learns particular items at the expense of learning other material or that the process by which the material is learned is different from "normal learning" (e.g., eidetic imagery). The specific purpose of this study was to examine these possible mechanisms in a particular patient.

BACKGROUND

This man, whom we will call B, was born on August 20, 1921. He was the first of two children born to reportedly normal parents. His sister is also reportedly of normal intelligence. He entered a state school for the mentally retarded in 1928 at the age of 6½ with an IQ of 54 (Stanford-Binet). At that time he was described as a poorly developed boy suffering from congenital syphilis.

At the time of testing, he possessed several abilities that placed him within the classification of idiot savant. He was able to play 11 musical instruments by ear, remember important dates such as birthdays, and draw elaborate pictures of houses. However, his most outstanding ability was calendar calculating. There are no indications in his records as to when or how his abilities developed, although it is clear that he possessed them at the time of his transfer to a second state school for the mentally retarded in 1949.

INITIAL TESTING

During his first visit to the laboratory, B appeared a little nervous but highly motivated to do well. He was tested on visually presented and auditory digit span, eidetic imagery, a paired-associate task, and his calendar-calculating ability.

The auditory digit span was taken from the Wechsler Adult Intelligence Scale. He was able to recite up to 5 digits forward and 3 digits backward when the presentation rate was 1 digit per second. Random series of numbers, ranging from 3 to 7 digits, were also presented to him typed on three-by-five index cards. Although an attempt was made to have him view each card for the same number of seconds as there were digits on the card, he would look at each card, read it rapidly to himself, and immediately look at the experimenter and recite as many numbers as he could. For the visually presented digit span, he was able to recall up to 5 digits forward and 5 digits backward. This increase in backward digit span might have been due to his reading the digits backward on the cards, as he had prior knowledge of the order in which he was to report them.

The tests for eidetic imagery followed the methodology of Haber and Haber (2) and also included the checkerboard figures of Gummerman and associates (3). No indications of eidetic imagery were found. His recall of the items within pictures was very poor in both content and color.

He was then given the paired-associate task in which he was presented with pictures of the heads of 10 females at a rate of 5 seconds per picture. During each presentation he was told a fictitious month and date of birth and

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asked to remember these. The pictures were presented for a total of three runs. For each picture he guessed the month and day of birth and was then told the "correct" answer. None of his guesses was correct, and the experiment was terminated. After these tests, it seemed evident that his ability to calendar calculate was not based on either eidetic imagery, a normal learning ability, or a large short-term memory capacity.

B was given a preliminary test of his ability to calendar calculate and was questioned on several of his answers regardless of whether or not he was correct. When questioned, he often referred to the previous year, to another month within the same year, or to a specific event that had happened to him a day or two from the date questioned. When questioned directly as to how he figured out the day, he denied using any mathematical formula or eidetic imagery. His responses to the direct questioning suggested the possibility that he was using some type of system, perhaps involving key dates and counting. If this were the case, his reaction times for dates closer to these anchor points should be faster than those distant from it. To test this possibility, an experiment was designed to further test his calendar-calculating ability.

EXPERIMENTAL INVESTIGATION

First Session

A series of 168 dates was constructed so that 1 date per month was given for each of the 14 odd-numbered years from 1943 to 1969. However, no date was given twice within a calendar year, and no month, date, day, or year followed itself in order of presentation within the list. The experimenter read the dates at a rate of approximately 1 second per item (month, date, year) and waited for B's response. When he responded, the experimenter nodded his head "yes" and went on to the next date. Thus B was reinforced for all responses regardless of correctness. For those dates for which no answer was given within 2 minutes, the experimenter simply went on to the next date. The testing lasted for approximately 2 hours, including a 10-minute break near the middle of the list. Both reaction times and self-corrections were measured by three independent judges from a tape recording of the experimental session. Only those reaction times to the first response, when that response was correct, were used.

Overall, B's first answer was correct for 134 dates (80 percent). The median reaction time was 7.9 seconds. On 6 of the dates, no answer was given. He caught himself on 10 errors and successfully corrected himself on 7 of these. He answered 18 dates incorrectly and did not attempt to correct himself.

The 14 years used in this experiment comprise 7 pairs of identical years. The 4 years in which B's responses were 100 percent correct were 1943, 1945, 1951, and 1965; these are years in which January 1 falls on a Monday or Friday. The two years with which he experienced the most difficulty were 1947 and 1969—both began on Wednesdays. In posttest questioning, he reported that he had been "framed" in 1947 and had been unjustifiably punished. No explanation was given for his relatively poor performance for 1969.

Table 1 presents a summary of the correct responses arranged according to months, days of the week, and 7-day periods. While the differences in median reaction times suggested that certain months may have been more difficult than others, this was based on only 10 to 12 data points for each month. No striking trend was found in days of the week (i.e., while Mondays might seem to be the most difficult in terms of reaction times, Mondays were highest on the percentage correct). When responses were broken down into periods of 7 days, the most prominent feature was the consistency of both reaction times and correct responses.

The results of this experiment seemed to indicate that B was not using a specific system of key dates and counting. However, there were certain variables within the reaction time data that appeared to call for further examination.

Second Session

The best and worst months, days of the week, and weeks were tested for 4 years that began on a Friday or a Wednesday and had not been previously tested. Thus, a new series of 128 dates was compiled to specifically test the dates of the month between the 15th and 28th that fell on a Saturday, Sunday, Monday, or Tuesday within the months of April, May, June, and December of 2 years (1937 and 1954) that began on a Friday and of two years (1941 and 1958) that began on a Wednesday. These dates were arranged and presented to B in the same manner as previously described.

A series of addition and subtraction problems of numbers between 1 and 17 was also devised to test B's ability in simple arithmetic skills. To test his use of a nonsystematic idiosyncratic code, dates of importance according to his state school records and general conversations were obtained. The testing consisted of giving him the list of 128 dates with a break approximately in the middle of this list. The test of arithmetic skills was given during this break. When the original list was completed, he was tested for an idiosyncratic code. For this testing, he was asked to give the day of the week as well as what happened to him on that day. As in the previous session, this session was tape recorded for later analysis.

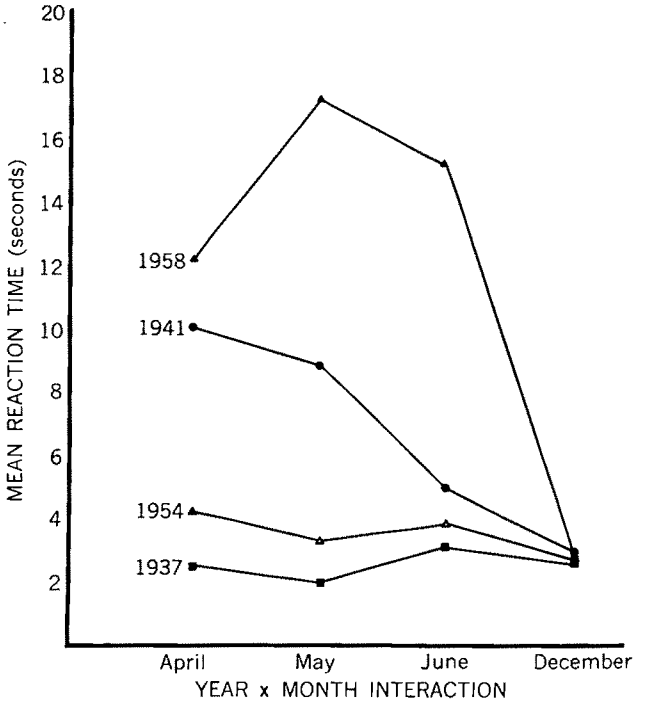
B's accuracy and reaction time were considerably improved, even though this session included the dates that should have been the most difficult for him based on his previous performance. Overall, his first answer was correct for 116 dates (91 percent). The median reaction time for these answers was 3.7 seconds. He corrected himself on 6 dates and gave no answer on the remaining 6. When these remaining 6 were given to him again at the end of the session, all of his responses were correct.

Separate analyses of variance were computed on the reaction times by dates (15th to 28th), weeks (15th to 21st versus 22nd to 28th), and days (Saturday, Sunday, Monday, Tuesday). Since none of these was significant, the reaction times were combined for an analysis of variance of

TABLE 1
Correct First Responses

Category	Percent of Correct Responses	Median Reaction Time (in seconds)
Month		
January	86	9.3
February	71	6.4
March	86	7.0
April	86	5.0
May	79	14.5
June	71	12.1
July	79	6.9
August	79	6.5
September	79	8.2
October	86	11.5
November	71	7.5
December	86	6.2
Day of the week		
Sunday	79	6.3
Monday	91	10.5
Tuesday	74	10.6
Wednesday	79	7.5
Thursday	79	8.2
Friday	68	8.6
Saturday	79	7.1
7-day period of the month		
1 to 7	88	7.3
8 to 14	74	8.0
15 to 21	82	6.6
22 to 28	73	9.0
29+	82	7.4

FIGURE 1
Median Reaction Times for Dates Presented in Years Beginning on a Friday (1937 and 1954) and on a Wednesday (1941 and 1958)



the years and months. This analysis indicated that the reaction times were significantly different between years beginning on a Wednesday and those beginning on a Friday ($F=25.42$, $p<.001$) and between months ($F=7.23$, $p<.001$) and that the Years × Months interaction (shown in figure 1) is significant ($F=4.54$, $p<.001$).

B could add simple numbers with little difficulty. However, it was noticed that he used his fingers during all calculations that involved a total greater than 10. He was unable to subtract at all. However, if the problem was made concrete (e.g., "If you have 3 apples and you give me 2, how many do you have left?"), he was able to do it with single-digit numbers but not with numbers larger than 10.

When asked what had happened to him on specific dates, B performed very poorly. He was correct on only 1 of the dates given (the date on which he was placed on family care), although he was able to give the correct day of the week for all.

DISCUSSION

None of the three mechanisms for calendar calculating suggested by Horwitz and associates (1) (eidetic imagery, high-speed calculation, and a substitute compensation for normal learning) seems appropriate as an explanation for the ability of this idiot savant. No indications of eidetic imagery were found either in direct testing or in auditory or visual testing for digit span. B's lack of simple arithmetic ability seemed to indicate that he could not calculate at high speeds. Even simple addition was a slow process for him, taking much longer than calendar calculating. The results of the paired-associate task, although designed to take advantage of one of his special abilities, indicated that he was unable to learn at a normal rate. At the end of three trials, he was still unable to give a partially correct answer (performing at less than a chance level while a normal control subject gave three completely correct answers after only one trial).

B did not appear to have a system for calendar calculating. Overall, it did not seem to matter what month, date, day, or year he was asked, with the exception of dates in years beginning on a Wednesday. In these years, months early in the year were difficult, but this difficulty was overcome when he reached December.

B's skill may have been due to a normal learning process coupled with the ability to sustain the great effort and concentration needed to memorize. He displayed no difficulty in maintaining concentration during hours of testing. This ability may have been aided somewhat by his knowledge of some of the systematic changes within the calendar. The only remaining explanation is not the ability to calculate days but a rote memory process similar to the memory of adolescents who learn the statistical information pertaining to their favorite sports.

Although there does seem to be something "special" about the calendar, the potential for concentrating and memorizing, albeit highly and narrowly focused, might be extended to other areas. Thus, the idiot savant is not a "normal" retardate, nor does he possess a special skill or capacity to memorize; his "special ability" seems to be that of concentrating for extended periods of time.

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Lithium Carbonate in the Treatment of Tardive Dyskinesia

BY FATMA A. REDA, M.D., JAVIER I. ESCOBAR, M.D., M.S., AND JOHN M. SCANLAN, M.D.

Six patients with tardive dyskinesia were treated with lithium carbonate in an open clinical trial. Evaluations using a new tardive dyskinesia rating scale showed statistically significant improvement in dyskinetic movements while the patients received lithium. This improvement was consistently observed in all patients but was relatively small when compared to the amount of pathology present.

INCREASED DOPAMINERGIC activity and decreased cholinergic activity have been proposed as basic pathogenic factors underlying tardive dyskinesia (1, 2). In fact, dopamine-blocking agents (3) and enhancers of acetyl choline (2) temporarily relieve symptoms of tardive dyskinesia.

Lithium carbonate diminishes central catecholaminergic activity by facilitating the reuptake of catecholamines (4). It also decreases the sensitivity of the receptor to dopamine (5). Two reports have appeared in the literature regarding the treatment of tardive dyskinesia with lithium carbonate (6, 7). Prange and associates (6) treated two tardive dyskinesia patients with lithium and observed marked dose-related improvement with lithium and relapse when placebo was substituted for lithium. Dalen (7) reported on a third patient who showed significant improvement in dyskinetic movements after treatment with lithium.

METHOD

We evaluated 16 patients with tardive dyskinesia who were being followed at a psychiatric aftercare clinic. The main criteria for inclusion in the study were unequivocal symptoms of tardive dyskinesia and a history of chronic intake of psychotropic medication. Only 6 patients fulfilled these criteria; 10 patients had to be excluded because of organic brain syndrome and other physical illness contraindicating the use of lithium. Table 1 presents the demographic data and medication history for the 6 study patients. Five patients continued to receive neuroleptics concomitantly with the lithium treatment, and one received lithium alone.

All patients were given 900 mg of lithium carbonate daily for weeks 1, 2, 5, and 6. During weeks 3 and 4 the patients were instructed to discontinue the lithium. Serum lithium levels were maintained between 0.7 and 1 mg/liter. Evaluations of tardive dyskinesia were made by three raters at the beginning of the study and at weeks 1, 2, 4, 5, and 6 using a tardive dyskinesia rating scale recently developed by us.[1] Patients were evaluated during live and videotaped interviews.

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The authors wish to acknowledge the collaboration of Ms. K. Frances Kemp, Research Assistant, Department of Psychiatry, St. Paul-Ramsey Hospital and Medical Center, and Robert Zimmermann, Ph.D., Research Associate, Department of Psychiatry, University of Minnesota Medical School, Minneapolis, Minn.

[1]The tardive dyskinesia rating scale is available upon request from Dr. Escobar.

TABLE 1
Demographic Data and Medication History for Six Patients with Tardive Dyskinesia

Patient Number	Sex	Age	Primary Diagnosis	Medication Other than Lithium During the Study	Length of Time on Current Medication	Previous Medication	Pretreatment Severity of Tardive Dyskinesia
1	F	48	Schizophrenia, mental retardation	Trifluoperazine	5½ years	Chlorpromazine Methylphenidate	Severe
2	M	56	Manic-depressive illness	None	3 months	Chlorpromazine Perphenazine Benztropine mesylate Diphenhydramine	Mild
3	F	56	Schizophrenia	Thioridazine Fluphenazine HCL Benztropine mesylate	2½ years	Trifluoperazine Chlorpromazine Imipramine	Mild
4	F	46	Manic-depressive illness	Mesoridazine Carphenazine	2½ years	Thioridazine Chlorpromazine Haloperidol Benztropine mesylate Diphenhydramine	Moderate
5	F	67	Schizophrenia	Perphenazine Amitriptyline Benztropine mesylate	7 years	—	Mild
6	F	62	Schizophrenia	Fluphenazine HCL	8 months	Thioridazine Chlorpromazine Trifluoperazine Imipramine Benztropine mesylate	Moderate

RESULTS

The statistical evaluation of the ratings on the tardive dyskinesia scale revealed that a subgroup of six symptoms—frowning, lip motion, jaw motion, choreo-athetoid finger, teeth clenching, and foot tapping or heel dropping—showed high reliability and occurred at a frequency adequate for evaluating this population group. These items were much more reliable rating factors than the remaining items in the scale, and when treated as a scale themselves they were essentially equivalent to the total scale. They showed a high degree of relationship to what the raters judged to be tardive dyskinesia as indicated in the global ratings of pathology on the tardive dyskinesia rating scale (severity was measured on a scale of 0 to 4). Their reliability and validity, as shown in this sample, indicate that they are quite adequate for use in research and clinical evaluations.

Another group of items—speech impairment, involuntary tongue protrusion, and abnormal gait—showed no core communality, had a very low intercorrelation, and had only a minimal correlation with the group of items previously described. The remaining symptoms in the scale—periorbital facial dyskinesia, blinking, cheek movement, and peculiarities in voluntary tongue protrusion—did not occur frequently enough in this sample to be adequately evaluated.

For the statistical analysis of lithium effectiveness, an average of the three raters' evaluations was used. The analyses were performed separately for the ratings made during live and videotaped interviews. For the analysis of each patient, a no-drug score was computed by taking the average of those ratings obtained while the patient was not receiving the drug, and a lithium treatment score was obtained by averaging those ratings obtained while the patient was receiving lithium. The difference between these two scores became the lithium treatment effectiveness score for each patient. The lithium treatment scores for the 6 patients were then added together and averaged. This average was tested with a one-sample t test for statistical significance. Table 2 shows the mean no-drug and lithium scores, the mean lithium treatment effect scores, and results of tests of significance.

The patients' improvement on lithium carbonate was shown on all of the factors in the scale. This improvement reached statistical significance ($p<.05$) with the aggregate of the symptoms of frowning, lip motion, jaw motion, teeth clenching, choreo-athetoid finger, foot tapping or heel dropping, and also with speech impairment, involuntary tongue protrusion, and abnormal gait (see table 2). Drug/no-drug differences for the total tardive dyskinesia scale and the global ratings of pathology also reached statistical significance ($p<.05$ using live ratings and $p<.01$ using videotape ratings).

In general, greater differences were noted in the videotape ratings. As can be seen in table 2, the patients' overall improvement was not large compared with their total pathology. Thus while all of the patients were rated as improved with lithium, this improvement was relatively small, and most of them retained significant symptoms of tardive dyskinesia.

TABLE 2
Mean Scores on the Tardive Dyskinesia Rating Scale

Item	Mean Scores*			Level of Significance
	No Lithium Therapy	Lithium Therapy	Effect of Lithium Therapy	
Group 1 symptoms: frowning, lip motion, jaw motion, teeth clenching, choreo-athetoid finger, and foot tapping or heel dropping				
Live ratings	8.00	6.70	1.30	$p<.05$
Videotape ratings	9.60	7.30	2.30	$p<.05$
Group 2 symptoms: speech impairment, involuntary tongue protrusion, and abnormal gait				
Live ratings	15.20	13.30	1.90	n.s.
Videotape ratings	15.80	13.40	2.40	$p<.05$
Total score				
Live ratings	29.70	25.00	4.70	$p<.05$
Videotape ratings	30.00	24.30	5.70	$p<.01$
Global ratings of pathology				
Live ratings	1.87	1.38	0.49	$p<.05$
Videotape ratings	1.83	1.43	0.40	$p<.01$

* The scoring system rated severity and frequency. For severity, 0 = none, 1 = mild, 2 = moderate, 3 = severe, and 4 = extreme; in addition, 0 = absent and 4 = present. For frequency, 0 = symptom not present, 1 = one every 10 or more seconds, 2 = every 5 seconds, 3 = every 2 seconds, and 4 = one or more per second or continuous.

DISCUSSION

There is as yet no effective long-term treatment agent for tardive dyskinesia. The current treatment of choice is discontinuation of neuroleptic drugs, as much in the hope of halting the progress of the disease as in ameliorating the symptoms. In the presence of psychotic symptoms there is a forced clinical choice between two "evils." It may be hypothesized that lithium carbonate decreases the neuroleptic-induced hypersensitivity of the dopamine receptor and that it is possible to continue giving "necessary" neuroleptic drugs concomitantly with lithium without as much fear of aggravating the neurological syndrome. Our results support these postulates, since lithium was shown to decrease the symptoms of tardive dyskinesia, particularly the oral and facial dyskinesias, when it was used alone or in conjunction with neuroleptic agents.

Since our study was not double-blind, the differences could be at least in part the result of placebo effect and/or rater bias. To verify this interesting preliminary finding, double-blind studies comparing lithium and placebo should be carried out on larger samples of patients. We foresee two shortcomings in the clinical use of lithium for tardive dyskinesia, namely, the incomplete relief of dyskinetic movements and the large number of patients with tardive dyskinesia who have other physical conditions that contraindicate lithium maintenance.

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LETTERS TO THE EDITOR

The "Wizards" Speak Out

SIR: It was with great interest that I read Judge David L. Bazelon's article "The Perils of Wizardry" (December 1974 issue). I believe that I understand most of the good intentions behind his appeal for psychiatry to become open to the legal adversary process. The medical profession of which psychiatry is a part has already developed an adversary system in its grand rounds and staff discussion that is far superior to anything currently available in the typical courtroom. In grand rounds, each piece of evidence is weighed and analyzed, and the staff attempts to integrate all available information in the most meaningful manner to achieve a pertinent clinical and therapeutic program.

The interest of the court, however, is, as Judge Bazelon stated, restricted—"not to determine whether a decision is correct or wise, but whether there has been a full exploration of all relevant facts and possible alternatives. . . ." Herein lies the difference: unlike the judicial system, physicians attempt to arrive at a wise and true decision.

Psychiatrists have been urged not to take the adversary cross-examination by attorneys as a personal insult. We often hear how opposing attorneys—regardless of the verdict—get together for a social drink. It may be worthwhile to point out that opposing expert witnesses may also have a drink together, but the victim of a cross-examination conducted with ferocious hostility is not very likely to react with equanimity. There is a proverb that says, "If you can't stand the heat, get out of the kitchen." Many psychiatrists have done just that. Others have just developed thick skins. It should be noted that the courtroom does not belong to the judiciary—it belongs to society. There is no reason for the heat to be turned up so high.

I believe judges are at fault for not exercising a judicial prerogative in controlling the bad manners of some attorneys. The administrative law judges in Social Security disability hearings give their claimants and attorneys plenty of scope for a comprehensive and reasonable analysis of all data but always keep the proceedings at the level of a scholarly and gentlemanly exchange. The same is not true of most other courts.

Judge Bazelon sounds like the man he warns us against. He urges us to participate in a process that is inimical to common sense and scientific fact finding and is a carry-over from days when the seriousness of the issue to be decided by the adversary process was whether Smith had stolen Brown's cow or whether Brown's cow had merely wandered, trespassed, and grazed on Smith's grass!

Judge Bazelon concluded by warning us that unless we do as he suggests, psychiatric decisions will be challenged more and more through the courtroom adversary process. In the same breath, he points out the abuses of psychiatry in the Soviet Union. He fails to mention that the judicial system was suborned first, and that it interprets the social reality in the context of the prevailing Marxist philosophy. All dictatorships have shown that the legal system is inevitably the first to be integrated into the prevailing political ideology and then enforces its actions and value systems on the rest of the country. And before we think it can't happen here, we should remember that only 40 years ago the Supreme Court reversed its decisions only because of the threat of Roosevelt packing it with his nominees. Although Congress voted Roosevelt down, the vulnerability of the "independent" judiciary was still apparent. The resolution of the Watergate crisis can also be attributed to a free press pulling a lethargic Congress. DeTocqueville wrote of attorneys, "If they prize freedom much, they generally value legality still more."

I would wager that the average citizen trusts the integrity of the medical profession far more than that of the judiciary and would not wish his private life discussed or aired in public.

MICHAEL A. PESZKE, M.D.
Hartford, Conn.

SIR: Judge Bazelon does not seem to understand the basic differences between the scientific clinical process and the legal adversary process. In the clinical process, behavior is viewed as a biological phenomenon with natural causality, and an explanation is sought to best explain all the data. In the adversary process, behavior is viewed as determined by common sense and logic, and an explanation that is most believable to the examiner is sought. In the clinical process, knowledge of a great variety of abnormal behavior is brought to bear to explain the data. In the adversary process, behavior is essentially idealized into bad or good, guilty or not guilty, etc., so that no in-depth knowledge of behavior is required. In the clinical process, definition and care of the individual's health is the primary social purpose, whereas the social purpose of the adversary process is to mete out the will of the people as established in their laws and to protect the accused from immediate, severe, and unjust retaliation by the people.

The author states, "I approach these [scientific] issues only as one charged with monitoring and supervising the decisional process." If this is how he feels about judges' responsibilities regarding scientific matters, then he is indeed the Wizard of Oz. Surely he means that he is charged with monitoring and supervising the legality of the decisional process, not the merits of the process itself.

Since it is quite apparent that the scientific process yields much more truth and understanding of behavior than do outmoded processes involving common sense, precedent, absolute ideals, etc., wouldn't the author's efforts be better spent in exploring the scientific basis for law, rather than trying to subject scientific psychiatry to an archaic adversary process?

AUGUSTUS F. KINZEL, M.D.
New York, N.Y.

SIR: Missing from "The Perils of Wizardry" was how the courts contributed to the creation of psychiatric wizards and how the courts themselves may become the wizards of psychiatry.

It is odd that the Judge appears to be praising the adversary procedure, the court's ability to determine facts, and the court's ability to monitor the decisional process because that judicial process is the one which defined, prepared, and sustained the role of psychiatrists as wizards in the courtroom. As the Judge's own comments in the Brawner decision and in many of his prior decisions have indicated, a concept like "mental illness/disease"—intended to be used in defining and classifying the care and treatment of patients—is not a useful one in determining justice. Yet in 20 years of unprecedented effort, the court system he speaks to has yet to be rid of the wizards, even though the vast majority of those called upon by the courts to play the wizard's role would prefer instead to spend their time on treatment tasks. The judicial system, not psychiatrists, should assume total blame for any wizardry in the courtroom.

The right-to-treatment concept adds another aspect in that it calls on the judicial system to become a wizard of mental health services. The judicial system's adversary process and decisional monitoring is now being called upon by some psychiatrists to evaluate and direct the development of mental health services. One system's tool may become another system's wizard stick. The mental health system's concept of mental disease may ill serve a system striving for justice and vice versa.

The Judge points out that the characters in the *Wizard of Oz* gained strength once their reliance on the wizard ended. In the Brawner decision, he pointed a way, which we can hope to be accepted some day by the courts, for the judicial system to gain strength through less reliance on the wizardry of psychiatry. Conversely, psychiatry will gain strength if it does not make wizards of the judicial system but fully faces its responsibility to evaluate and develop services for the mentally ill.

ROGER PEELE, M.D.
Washington, D.C.

SIR: When a man who works in flowing black robes, upon whose entrance all stand in respect, before whom all must utter holy words before speaking further, and who may consign some to years of confinement and others to part with their fortunes or even their lives speaks to me of wizardry, I feel I should listen. Judge Bazelon offers several criticisms of psychiatry and an admonition; each requires a response.

He suggests that we are failing in our task by merely treating the victims of poverty, discrimination, and segregation rather than removing the causes of suffering and disability. Psychiatry is a medical specialty, not a political technology. These social disorders indeed must be remedied—but not by psychiatry.

He suggests the adversary process can point the way to wisdom in psychiatric decisions. The lawyers' faith in argument is understandable, if not convincing. I would prefer to see the adversary process subjected to scientific scrutiny as a tool for revealing truth before I critically accept it as a valid measure of clinical judgments.

The Judge warns against the dangers of psychiatric labeling. The danger is real, but its source is not apparent. Like every group, psychiatrists have developed their own jargon to facilitate communication relative to their own tasks and purposes. It is precisely when other groups usurp the jargon of clinicians for nonclinical tasks and purposes that the danger arises. If others do not like our language and find it full of bad words, let them leave it alone and speak only their own language. It is not meant for them anyway.

Judge Bazelon's warning is flattering. He recognizes that as our methods become more effective, we must be watched more carefully. I fully agree. All who exercise power should be watched carefully: psychiatrists, politicians, business executives, and judges.

FRANCIS J. DURGIN, M.D.
Syracuse, N.Y.

Judge Bazelon Replies

SIR: One general theme of these letters interests me—that psychiatrists are in possession of scientific facts about people which they can reveal to the noncognoscenti. It is suggested that burdening psychiatrists with the adversary process in either the revelation of those facts in the courtroom or in their discovery and application in the hospital is fundamentally unsound, as scientific facts are obscured by the adversary process and in general the adversary process is not mete for scientific discovery. This general theme could be summarized as follows: "No amount of cross-examination will shake, faze, or rattle an expert witness loaded with facts and free of bias, emotional, pecuniary, or other."

I have yet to hear of such a witness. First, psychiatrists are not in possession of what are properly defined as scientific facts. I quote from a forthcoming article in *Prism* by Nobel laureate Dr. S.E. Luria (1).

> An open-ended, undisprovable theory is no scientific theory at all. In this sense, for example, scientific theory differs from such hypothetical structures as Freud's psychoanalytic theory. No matter how much illumination psychoanalytic theory may throw on certain aspects of human behavior, it cannot be considered a scientific theory in the same sense as the theory of evolution: *it is not clear that Freud's theory potentially could be disproved by any critical set of tests.*[emphasis added]

Psychiatrists are expert at making clinical judgments about people; but a clinical judgment is not scientific fact, for the reasons Dr. Luria states. And clinical judgments bring into play the human biases, which are most evident in the making of social judgments such as those implicated in psychiatric diagnoses. The adversary process, in theory, operates to bring the biases that shape judgments, clinical or otherwise, into the light of day and subject them to critical analysis. In this manner, the adversary process is relevant to psychiatric judgments in the courtroom or in the hospital.

When I say "biases" I am, of course, referring to the implicit social judgment involved in labeling a person "neurotic," "psychotic," etc. I also refer to other social judgments—such as a psychiatrist recommending commitment because even though a particular individual does not meet the standards for civil commitment, he is really in need of treatment and does not know it. Another example would be a criminal offender who has committed such a heinous crime that even though he may be psychotic, the psychiatrist reports that the crime was not a product of psychosis because of his own "law and order" beliefs. Still another would be a judgment that commitment would be so damaging to a person's family that the psychiatrist recommends against it. Psychiatrists are aware of the various unarticulated factors that bear on their clinical recommendations. Lawyers and judges are aware of similar factors at work in the judicial process. The point of the adversary system is to enable persons injured by the use of such factors to force them

into the open and to challenge their validity or to assess their weight.

The purpose of the adversary system in this aspect is twofold: to separate "facts"—data about human behavior—from social value judgments and to determine whether certain social value judgments are legitimate (thus performing a permissible role in social decision making) or illegitimate. Even when social value judgments employed by a psychiatrist are legitimate, we should know of their existence in order to assess their proper weight and to intelligently examine the decision to which they refer. When the judgments are illegitimate—e.g., when a psychiatrist's personal beliefs on law and order influence his opinion—the adversary system permits a party to place these judgments on the record and to cause the ultimate decision maker to question the entire validity of the expert opinion that incorporates an illegitimate value premise. In this manner, the adversary system deals with the reality of human bias.

All the foregoing applies equally well to the public surveillance of other highly specialized professions on which the operation of a complex civilization depends. Today every profession—including the law—is being challenged by those who believe that trust should rest not on mystique but rather on what the public knows about the profession's exercise of its expertise.

For better or worse, clinical psychiatric judgments affect the individual rights of many people, rights that the courts have traditionally protected from improvident invasion. The legal system recognizes those rights and thereby the individual dignity of every citizen through the adversary process, in which every citizen has an opportunity to explain his or her point of view and to contradict opposing points of view. The adversary process is thus a rule of fundamental fairness to those whose rights might be invaded, and it legitimizes decisions to so invade personal rights. It is a forthright recognition that the interests of doctor and patient may diverge and that the patient has the right to question the doctor's wisdom when this happens. Thus, even if we were convinced that psychiatrists possess scientific facts, it would still be desirable to employ the adversary process in making decisions which substantially affect human rights.

This is not to say that the adversary process is the sole or even the main source for the derivation of scientific or psychiatric knowledge. University seminars, grand rounds, staff discussions, academic writing, and traditional forms of research all serve to increase our understanding of the difficult questions involved in analyzing human behavior. But the law and, in many instances, psychiatry cannot wait for the culmination of scientific truth-finding processes before making judgments in individual cases. Courts must decide controversies as they arise, sometimes long before experts reach a consensus. The adversary process is particularly appropriate for necessarily tentative behavioral knowledge.

Above all, it must be remembered that the adversary process does not serve merely to discover scientific facts or clinical judgments. It is directed toward the making of legal decisions, such as whether a criminal defendant can be justly held responsible for his actions or whether an individual should be subjected to a certain kind of confinement against his will to protect society or to provide care for him. These questions clearly demand that social and moral judgments be taken into account, and the obstacles to resolution of such questions by neutral experts become insurmountable. Indeed, the clinical judgments of psychiatrists are inevitably concerned with such social and moral judgments. The point is that these judgments are not to be made by doctors and experts alone.

When I recommend the adversary process to the medical professions, I find myself assailed with generalized criticisms of the legal profession and its misuse and abuse of the adversary system in practice. I too have often criticized the legal profession. No one can look with pleasure on the existence of "defendants' " psychiatrists and "government" psychiatrists, nor can one condone the incompetence, pretentious belligerence, and insensitivity of many lawyers—and, I must add, many psychiatrists—who operate in the delicate area of human behavior. My claim in favor of the adversary process lies in its theory, and I believe that theory is unobjectionable. Failure in practice should lead us to seek reforms, but I do not think those failures indicate any essential flaw in the theory. In any event, no model of truth finding has yet appeared that does not entail even greater defects than those perceived in the operation of the adversary process.

I understand the factors that lead many psychiatrists to avoid the adversary process. It is not a pleasant or a gentlemanly affair to have one's opinions challenged and one's biases exposed and utilized to disparage one's conclusions or to attempt to explain a point of view to a party whose interests prevent acceptance of that point of view. Neither is it pleasant to convict seriously disturbed persons of crimes for which they are not truly responsible or to incarcerate mentally ill people indefinitely with no promise of serious attention to their problems. Perhaps the psychiatric profession, like the judicial profession, would rather not confront society's irreconcilable dilemmas and failures in favor of sweeping them under the rug. However, the only way for any of us to do more than act as society's street sweepers is to suffer this disconcertation and unpleasantry as the price of compassion for our fellowman.

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JUDGE DAVID L. BAZELON
Washington, D.C.

Clerical Guidelines for Psychiatric Care

SIR: On behalf of the membership of the New Mexico Psychiatric Association, I would like to bring to the attention of APA members the publication of a complete set of in- and outpatient clerical guidelines for all psychiatric illnesses, developed by the New Mexico Foundation for Medical Care. In 1971 the New Mexico Medical Society established the Foundation for Medical Care to assist the local welfare department on its budget for medical services. The foundation was thus a professional review arm of the medical society that also had stated fiscal goals. A psychiatric professional review committee began functioning in June of 1971. All claims for psychiatric and psychological services have been reviewed on an individual basis by a committee of psychiatrists and psychologists. Another committee, most recently headed by Dr. Samuel Swedenborg, completed work on the clerical guidelines, which we hope will increase the efficiency of the review process.

A unique aspect of these guidelines is that they were submitted to the full membership for approval before adoption. When they were first submitted in September, the membership voted against them, necessitating further revision. There was final approval in December, with only one dissenting vote. While the process was sometimes tedious, we are all gratified that the entire membership participated in the completion of this important document. It is our intention to make it a practical, dy-

namic instrument under constant review, dictated by our experiences with the review process. We have gained much experience in psychiatric review and offer our guidelines to any interested district branches or others who may wish to examine them.

WILLIAM STENNIS, M.D.
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New Mexico Foundation for Medical Care
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Another Opinion

SIR: Dr. Charles Aring's review of Pincus and Tucker's *Behavioral Neurology* (December 1974 issue) is singularly beside the point and could deprive many readers of what I consider to be an excellent first book for the physician who is concerned with neuropsychological function and dysfunction.

Dr. Aring states that a discussion of symbolic functioning is a requirement for a text on behavioral neurology, that Drs. Pincus and Tucker are "ill at ease with symbolic functioning" and "plump for the organic origin" of such conditions as childhood autism, minimal brain damage, depression, and schizophrenia. For these reasons, he does not recommend the book. I disagree.

Behavioral Neurology is a unique book. There are many texts concerned with symbolic behavior; this is the first to bridge the gap between brain dysfunction and traditional psychiatric disorders. While Dr. Aring might have been happier with more "psychodynamics," he failed to note that the book is well written and well documented and that its basic concepts (particularly in the chapters on seizure disorders, the limbic system, and organic brain syndromes) are essential for psychiatric residents who must evaluate, diagnose, and treat patients with serious behavioral disorders which are often the result of brain dysfunction. There are few statements in *Behavioral Neurology* that are not supported by data or reference. This fact alone makes it a rare book for the psychiatrist.

I would have hoped for more ecumenicism from Dr. Aring and for a discussion of the thought-provoking sections on the genetic studies of seizure disorders, the relationship of limbic functioning to violence, the data relating cerebral dysfunction to schizophrenia, the discussion of the aphasias and localization of brain function, and the relationship of seizure disorders to psychosis, sexual activity, and EEG findings.

MICHAEL ALAN TAYLOR, M.D.
Stony Brook, N.Y.

Tolerance Phenomena With Major Tranquilizers?

SIR: I wish to describe the case of a 42-year-old man who had been suffering for many years from paranoid ideation and persecutory delusions until a physician prescribed 2 mg of trifluoperazine hydrochloride (Stelazine) twice a day. His symptoms disappeared with this regimen and reappeared whenever he stopped taking the medication. All went well for 6 years, after which time the symptoms recurred despite continuance of the same medication and dosage. The patient consulted me at this point and I increased the dosage to 2 mg three times a day and later to 2 mg 4 times a day, but his symptoms persisted. I then took him off all medications for a week and substituted other phenothiazines, none of which were effective. After another drug-free week, I reinstated him on 2 mg of trifluoperazine hydrochloride twice daily. To my surprise and pleasure, the paranoid picture disappeared and he responded again to this regimen, as he had done for 6 years. Unfortunately, this happy result proved to be short-lived, lasting only a week, after which time the full-blown symptom constellation reappeared.

My next move was to take him off all medication for 3 weeks and then again give him 2 mg of trifluoperazine hydrochloride twice daily. The symptoms disappeared and, months later, have not reemerged.

This case motivated me to examine the records of other patients to see if I could discover a similar pattern and to ask colleagues if they had encountered such findings. I reached the conclusion that I was dealing with a frequent phenomenon that raises important questions and challenges some long-held assumptions.

We tend to believe that only the "minor" tranquilizers create tolerance (i.e., the drug "loses its kick" and higher dosages are required to achieve the desired effect). Clearly, this case illustrates that a "true" tolerance to trifluoperazine hydrochloride did not occur, for increasing the dosage should have worked had this been the case. Another factor indicating that a "true" tolerance did not form was the extremely long time it took for the drug to become therapeutically ineffective. Hence, it would appear that a resistance or refractory period develops after a long period of time. Moreover, if the drug is reintroduced during such a state of relative refraction or resistance, it will be ineffective.

It makes sense to stay with a drug that has worked for a long period of time. Only if the approach I have outlined fails are we justified in trying other phenothiazines. The period of resistance or refractory period will have to be determined empirically.

I would like to invite the readers of the *Journal* to contribute their experience regarding the development and management of "tolerance," resistance, or refractory periods to the phenothiazines, thioxanthenes, and butyrophenones. I hope this letter will alert physicians to tolerance-like phenomena encountered with phenothiazines. Too many physicians assume that the "major" tranquilizers can, and even should, be maintained indefinitely.

Concern with tardive dyskinesia has motivated many of us to give drug-free holidays, to reduce dosages, and to prescribe trial periods of discontinuance of phenothiazines. The case I have reported provides another compelling reason to adopt these measures.

CHARLES ROSENBLOOM, M.D.
Upper Montclair, N.J.

An Alternative to "Borderline Patients"

SIR: This letter is prompted by the excellent article "Defining Borderline Patients: An Overview," by John G. Gunderson, M.D., and Margaret Singer, Ph.D. (January 1975 issue).

Instead of the terms "borderline patient" or "borderline state," I propose the term "chronic polymorphous psychiatric syndrome." "Borderline" is too vague. The term "pseudoneurotic schizophrenia" covers only one facet of the clinical manifestations. The term I propose could be meaningful to nonanalytic clinicians as well as psychoanalysts. This is not to gainsay a schizophrenic substrate, but the proposed rubric does suggest the rapid fluctuations and varied spectrum of the clinical picture and, perhaps, even the interludes of apparent normality.

J. EDWARD STERN, M.D.
El Paso, Tex.

Prevention of Iatrogenic Epidemics

SIR: Recent mention in the professional (1) and lay press (2) indicates a continued concern about iatrogenic phocomelia. These reports do not describe how another thalidomide-like epidemic may be prevented except by indicating that pregnant women should take less medication, specifically tranquilizers.

B.C. Glueck, Jr., M.D., and I have reported a model that would prevent the recurrence of such iatrogenic epidemics. Interested readers may find this in the March 1973 issue of *Preventive Medicine*. I would also be willing to send reprints to those who write to me at the address below.

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MERVIN ROSENBERG, M.D.
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A Physical Symptom in Bipolar Episodes

SIR: I would like to call to *Journal* readers' attention an unusual physical symptom in a woman with manic-depressive illness. I hope this will be of interest to people doing research on the periodic mental and physical changes of this disorder.

The patient, a 56-year-old married woman, consulted me in 1974. She reported an 8-year history of mood cycles. The first episode was hypomania, with irritability, excessive energy, and excessive talking. After that, she had episodes every 2 months. The onset of each episode was heralded by a sensation in both ears of "fluid moving around." This was not accompanied by pain or by a sound but was attended at times by a feeling of intense pressure deep in each ear. The sensation lasted only a few minutes each time and occurred several times during the first 3 days of each episode. Over the next few days she became lethargic, slept more, and experienced depressed mood. The depressed phase lasted about 2 weeks and was succeeded by a hypomanic phase lasting about a week, during which she became irritable and overactive. She would be well for about a month before this process would recur. She has had relief of her symptoms on lithium carbonate maintenance (900 mg a day, with a blood level of .75 mEq/l).

Her report of a sensation of fluid moving deep in the ear may be of physiologic significance in the "switch over" from the normal process to an episode of illness. She is an extremely intelligent and reliable person, not given to histrionics, and she reports no other somatic symptoms. She has had a total of approximately 40 to 50 bipolar cycles and says the depressed phase has always begun with this symptom.

RICHARD W. HUDGENS, M.D.
St. Louis, Mo.

A Request for Clarification

SIR: In their article "Penfluridol: An Efficacious Long-Acting Antipsychotic Compound" (June 1974 issue), Donald M. Gallant, M.D., and associates did not mention the criteria by which they diagnosed their subjects as "chronically ill schizophrenic patients." I am sure that the authors know that the concept of schizophrenia varies from one psychiatrist to another. In addition, it is known that nonparanoid schizophrenics respond differently to medication than do paranoid schizophrenics—a distinction the authors did not make—and that short-stay patients (i.e., hospitalized under 10 years) respond differently than do long-stay patients. It would have been better if these results had come from long-stay patients.

RAM N. KRISHNA, M.D.
Brentwood, N.Y.

Dr. Gallant Replies

SIR: The patient population we reported on has been extensively described in a number of articles originating from our research unit (1, 2). Concerning the diagnostic categories, we tend to discriminate among schizophrenic patients in a more basic way than the presence or absence of paranoia, which we consider to be surface symptomatology secondary to the basic disease process of schizophrenia. The schizophrenic patient who is severely ill and has shown a poor response to therapy is the type of individual we see at the Tulane Psychopharmacology Unit. Our terminology considers the patient to be a process schizophrenic—what has been termed systemic schizophrenic psychosis. Thus this particular subgroup of schizophrenics is composed of paranoid and hebephrenic types and several catatonic subgroups who all show a similar response to antipsychotic medication.

On the second page of our article we detailed both the median length of hospitalization and the range of hospitalization for both the drug and placebo groups. Perhaps this will clear up Dr. Krishna's confusion.

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DONALD M. GALLANT, M.D.
New Orleans, La.

Comments on a Press Release from Blue Cross

SIR: The Blue Cross Association recently distributed to its district representatives a press release that described, with evident approval, the remarks of Dr. E. Fuller Torrey in a recent issue of *The Washington Post* (1). Briefly, Torrey stated that psychiatry and psychiatrists will soon be dispensed with. He divides psychiatric patients into two types: those who have "problems of living" and could be treated by psychologists or other nonmedical practitioners and those who have "true brain disease," whose drug treatment could be managed by general practitioners or internists. It is said that Torrey claims that insurance money and medical personnel have been diverted to treating the group with problems in living to the detriment of those with true mental illness, e.g., manic-depressive illness or schizophrenia. He feels that the former group is responsible for the "massive cost increases" in coverage of psychiatric benefits by insurance plans. Torrey's article also discussed some of the

social consequences of psychiatric self-aggrandizement, but Blue Cross did not refer to these portions.

Because psychiatry has always been somewhat of a step-child to the Blues, I am more than a little concerned by their apparent acceptance of Torrey's thesis, which implies that limiting psychiatric coverage to those with true mental illness (defined as the presence of an actual brain disease) and denying it to those with problems in living will result in improved care of the "truly sick" and lower health insurance costs. The practical workings of such a system would leave much to be desired.

For example, patients who make repeated suicide gestures or are addicted to alcohol are generally considered to be suffering from problems in living. Torrey presumably would propose that health insurance cover only the medical complications of these behaviors, such as coma or cirrhosis of the liver. Any attempts to resolve the behavior underlying the medical complications would be considered nonmedical treatment, and presumably would not be covered. The ordinary patient would only be able to receive such treatment if he were in jail or in a public hospital. Such a solution might not be unjust, but if it prevented adequate and effective treatment for these chronic problems, it might be more expensive in the long run.

It would also be difficult to distinguish between Dr. Torrey's two categories of patients in actual practice. A chronic schizophrenic who suffers a relapse in response to some stressful event has a brain disease that renders him more vulnerable to problems in living. What if some personality disorders are shown to be genetically determined? What if the genetic component proves to be very small? Will third parties provide partial coverage?

The real issue here is one of control. With the enormous increases in health care premiums, the Blue Cross Association is understandably anxious at the prospect of having to pay for hospitalization or psychotherapy for relatively healthy persons suffering from everyday fatigue, anxiety, or discouragement.

It is imperative that the psychiatric profession define reasonable criteria for necessary psychiatric treatment, preferably in the context of a dialogue with the third parties who will be expected to pay for it. Much hard work will be necessary—the development of mutually satisfactory standards will require valid outcome studies, not just a description of the status quo. I fear, however, that the implicit acceptance of viewpoints like Dr. Torrey's by medical insurers will cut off such a dialogue before it can even begin.

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WILLIAM BRADEN, M.D.
Providence, R.I.

More on Dominance, Freud, and Sex

SIR: The letter by Roger K. Pitman, M.D., in the November 1974 issue of the *Journal* amending Freud's formulation re the need of certain neurotic men to choose women over whom they can feel dominant in order to experience full sexual potency overlooks the particular insight of Freud's formulation.

The notion of dominance seems insufficient to describe the affective components in the relationship of such men to their sexual objects. The specific quality of their attitude is a constant feeling of loss of respect, a sense of contempt and inferiority, occurring primarily because a positive regard is experienced as inhibitory to full potency. The general sense of dominance suggested by Dr. Pitman is not sufficiently precise to delineate their emotional attitude toward women. There are human relationships in which dominance by no means implies loss of respect, e.g., the tennis player who dominates the match does not lose respect for the opponent who gives him a good game.

According to Dr. Pitman's formulation, the little boy simply wants to maintain a notion of dominance over his mother in order to win her. This does not take into account the question of conditions for potency. The issue is not winning but rather establishing the proper ambience for sexual satisfaction. If we consider Freud's original formulation, we note that the presence of an aggressive and vengeful attitude toward the mother as part of the total sexual experience is clearly implied. Fulfillment thus serves to express a sadistic as well as loving component.

HARRY TROSMAN, M.D.
Chicago, Ill.

Dr. Pitman Replies

SIR: Dr. Trosman's objection to my formulation seems to be that it does not pay sufficient heed to the strong sadistic component of the relationship of the men in question to the sexual object. I would like to mention that my letter originally read as follows: "Certain individuals need to choose women over whom they can *unquestionably* consider themselves dominant to experience full sexual potency." The word "unquestionably" was deleted by the *Journal*'s editorial staff, and I believe the clarity of my argument suffered somewhat. I meant to imply that the sexual style of these men constitutes an exaggerated (and therefore neurotic) case of what I concur with Dr. Abernethy is a universal need on the part of the male to be dominant sexually for optimal potency. A rereading of Freud's article indicates to me that he saw the need to "lower" the sexual object to achieve full potency as more or less universal to varying degrees in men in civilized society, and not just peculiar to a neurotic minority.

I agree with Dr. Trosman that the concept of dominance alone does not explain why some men need to go to the lengths of arrogance and sadism to achieve potency. Could it be that sadism is an extreme attempt at dominance, and that a clinical continuum exists in potent heterosexual relationships between healthy male dominance at one end and sadism at the other? Considered in this way, the two phenomena are distinguishable, yet in a sense they derive from the same source. Those individuals at the extreme end of the continuum would be likely to have the most tenuous grasp on a sense of themselves as able to be dominant with women at all, possibly deriving from childhood experiences.

In a defense of Freud's formulation, Dr. Trosman takes issue with the usefulness of seeing the little boy in fantasy as attempting to "win" his mother. Perhaps he is not aware that this choice of language is Freud's own: "die Mutter durch Erniedrung zum Objekt für die Sinnlichkeit zu gewinnen" (1, p. 83), "gewinnen" meaning win or gain. Strachey translates this as "by debasing the mother to acquire her as an object of sensuality" (2, p. 183), but another translator chose the following wording: "by degrading her, to win the mother as an object for sensual desires" (3, p. 63). Thus, Freud apparently thought that winning was an issue, and I suspect that if he had been familiar with recent work in ethnology, he would have recognized the applicability of the concept of dominance to the phenomenon he described.

I would like to thank Dr. Trosman for reminding us that dominance does not necessarily imply loss of respect. He illus-

trates this in the metaphor of sports competition, but I am sure he would extend it to male-female sexual relationships as well. In her letter in the December 1974 issue of the *Journal*, Joyce Kales, M.D., expressed anxiety about sexist implications of Dr. Abernethy's hypothesis and contrasted "power-dominance" models of human sexual roles with "satisfaction-intimacy relationships based on equal, shared needs." Under the right conditions, this distinction may be illusory—consider the intimacy involved in a man sharing his need to "win" a woman with her equal need to "be won" by him.

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3. Freud S: The most prevalent form of degradation in erotic life (1912), in Sexuality and the Psychology of Love. Edited by Rieff P, translated by Riviere J. New York, Cromwell-Collier Publishing Co, 1963

ROGER K. PITMAN, M.D.
Cambridge, Mass.

Phentermine Addiction and Thyroxine Abuse Associated with Hypothyroidism

SIR: Potentiation of the effect of the central nervous system stimulants by thyroxine has been reported by several authors (1, 2). I had the opportunity to follow a hypothyroid patient who was using toxic doses of thyroxine medication in combination with phentermine for an antidepressant effect.

The patient, a 56-year-old woman, developed hyperthyroidism 20 years ago and was treated 2 years later with ^{131}I, which resulted in postradiation hypothyroidism, accompanied by prominent CNS symptoms (tiredness, depression, poor memory, and difficulty concentrating). Those symptoms were not completely corrected by adequate thyroid medication compensating for clinical hypothyroidism. However, they responded to toxic doses of exogenous thyroid hormones in combination with a CNS stimulant. The patient was originally taking *d*-amphetamine sulfate, but for the last 4 years she has been taking phentermine (Ionamin). She progressively increased the dose of her medication to .5–.7 mg of sodium levothyroxine (Synthroid) daily and 30 mg of phentermine several times a day. Every attempt to decrease or discontinue any of the two drugs leads to exacerbation of the CNS symptomatology. The toxicity of the medication is manifested especially by atrial fibrillation with rapid response of the ventricles. Her serum thyroxine is consistently higher than 16 μg/100 ml (normal ranges from 4.5 to 11.5), the effective thyroxine ratio is elevated to 1.3 plus (normal is 0.86 to 1.13), and her serum thyroid stimulating hormone is suppressed to nonmeasurable values.

In my opinion, the previous long-standing hyperthyroidism modified this patient's perception of well-being in such a way that she now feels a need for supranormal stimulation of her central nervous system by a combination of high doses of thyroxine and the CNS stimulant.

The case also demonstrates that chronic use of phentermine can lead to addiction with little anorectic effect. To my knowledge, addiction to phentermine has not been reported previously. There is one report (3) of psychotic reaction following phentermine medication.

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LUBOMIN J. VALENTA
East Lansing, Mich.

Corrections

The observations reported in Dr. William Thornton's letter to the editor on page 302 of the March issue of the *Journal* were incorrectly linked to his work with the University of Chicago Drug Research Clinics. This work was in fact undertaken when Dr. Thornton was in private practice in Naples, Fla.

On pages 350 and 354 of the March issue of the *Journal*, Dr. Murray Morphy's name was misspelled.

The staff regrets these errors.

LETTERS TO THE EDITOR are welcomed and will be published, if found suitable, as space permits. Like other material submitted for publication, they must be typewritten double-spaced. The letters should not exceed 500 words, including references, unless a special arrangement has been made with the Editor, and they will be subject to the usual editing. Receipt of letters will not ordinarily be acknowledged.

BOOK REVIEWS

Between Belief and Unbelief, *by Paul W. Pruyser, New York, N.Y., Harper & Row, 1974, 286 pp., $10.00.*

The uniqueness of this book lies in its dynamic analysis of belief and unbelief as closely related in terms of the functions they perform in psychic life. Dr. Pruyser is a clinical psychologist, Harry March Pfeiffer Professor at the Menninger Foundation, one of the coauthors of *The Vital Balance* (1), and author of *A Dynamic Psychology of Religion* (2).

Dr. Pruyser undertook this book to deal with "the contemporary phenomena of secularization, disaffiliation from religion and religious institutions, disbelief, and unbelief" (p. xii), which he had not analyzed in his previous writings. The discussion focuses as much on belief as on unbelief, however, because Pruyser sees an increase in interest in transcendental experiences, charismatic movements, and folk religion in recent years as well as a more long-term process of secularization and decline in belief and commitment.

The thesis of the book is that both belief and unbelief are to be understood in terms of man's pursuit of happiness. This pursuit is seen in dialectical relation with tension. Pruyser states, "The life worth living and examining is a life lived in tension, ... tensions are a perennial feature of the human condition" (p. xvii). This tension is demanding on the mind as well as on the feelings.

Pruyser's position on this subject has kinship with Freud's pleasure-reality principles, especially if more attention is given the ego. However, the range of fields of knowledge from which Pruyser draws is greater than Freud used. Pruyser also analyzes the dynamics of unbelief as well as belief as rigorously as Freud discussed the latter.

Although beliefs of a religious kind, along with corresponding unbeliefs, are central to this book, Pruyser also considers other kinds of belief and unbelief. Among the topics specifically analyzed are alienation, dependency, autonomy, mystery, options, Providence, fantasy, and the various meanings of reality. Object relations theory is used to suggest that both beliefs and unbeliefs may be either love objects or hate objects.

Since he has worked in a psychiatric setting for a quarter century, Pruyser's judgment that many psychiatrists and their colleagues feel uncomfortable in assessing the religious beliefs of their patients suggests the special value of this book for mental health professionals. There is no better way to feel more at home in any kind of appraisal than to understand the dynamics behind outward appearance.

Despite his compressed but readable discussion of ontological bases of belief or unbelief, Pruyser has no quarrel with the need to take a nonphilosophical view of the world in clinical practice. However, he implies that even psychiatrists may permit clinical pragmatic necessity to produce what is widespread throughout our society, namely, a view of reality that is too dull and too flat.

The author's style has admirable clarity, but the depth and complexity of his analyses are such that even speed-reading psychiatrists are likely to have to slow down. The process is very much worth the effort. Even as a theologian who has also studied psychiatry and psychology for many years, I found that this book often revealed gems of insight that had not occurred to me.

I have only two criticisms of this work, and they may be matters of choice. The first is Pruyser's decision not to use a developmental schema to deal with his topic. Although he justifies his approach very well, more attention to developmental stages would have increased the book's value for clinicians. The second critique is not of the way some topics are analyzed, but of the way the questions are asked. I would differ, for example, on the way the question of Providence is posed.

However, any such critiques may simply be differences in perspective between a psychologist knowledgeable about religion and theology and a theologian who has studied psychiatry and psychology.

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SEWARD HILTNER, PH.D.
Princeton, N.J.

Conundrum, *by Jan Morris. New York, N.Y., Harcourt Brace Jovanovich, 1974, 174 pp., $5.95.*

This book is well named. The condition known as transsexualism has long puzzled scientists and laymen alike. Psychiatrists have not penetrated the mystery sufficiently to be in accord regarding etiology. Although most psychiatrists agree that it is a proper course of treatment in some cases, surgical transformation is nevertheless not a complete cure. Not all follow-up accounts reflect the satisfactions reported by Ms. Morris. Many transsexuals still complain that the surgical change is not enough, that the feeling of normality still eludes them. Tragically, suicide is too often the ultimate solution to this problem.

Psychiatrists have long credited writers with a special intuitive sense that allows them to achieve an understanding of human emotional problems long before science can produce more substantial theories of etiology. How fortunate it seemed that a proficient author, James Morris, had produced an autobiographical account of his transsexualism and sexual transformation. In its pages might well lie a new answer to the riddle of why some biologically normal males have a lifelong conviction that they are women trapped in a man's body. What force drives these individuals to sacrifice everything to obtain as complete as possible an approximation of female anatomy?

In a search for new insights of clinical interest I will leave the literary qualities of Morris' work to others more qualified to comment. James was the youngest of three sons born in the 1920s to a mother who wished strongly for a daughter. In his early years the boy was closely attached to his mother, especially after his father died when James was less than five years

old. Morris describes himself as a solitary child but not effeminate. He was well accepted as a boy in school.

His experiences as a student in a select, cloistered choir school at Oxford from about ages 9 to 12 seem to have had an important influence on the development of his concept of femininity, even though Morris dates his gender conviction back to age 3. Clothed in choir robes and caught up in a preoccupation with the Virgin Mary, he felt closer to being a female than a male, although he had never seen a naked woman. He hated sports and blushed to be seen nude by fellow students.

From the ages of 12 to 17, Morris fell to the bottom of the pecking order at preparatory school and suffered frequent beatings at the hands of student leaders. He played the passive role in a series of homosexual romances, which he seemed to have thoroughly enjoyed, even though he found anal intercourse unaesthetic. A process of dissociation appeared to set in about this time that continues to serve defensively. His pleasures came from the olfactory sensations (smell of hay or rotting apples) present during these early sexual acts.

In the Army for the next three years Morris maintained his chastity and sublimated his sexual feelings in a variety of other sensual delights—smells, foods, sights, and sounds. At the age of 21 he fell in love and married. Although he found intercourse distasteful, he fathered five children.

His work, first as a reporter and later as an author, involved long absences from home. Morris reports that sexual relations were infrequent in his marriage but implies that both partners had other sexual outlets during the prolonged separations. When Morris was about 35, he began to experiment with female hormones. Around this same time one of his children died in early childhood. The migraine headaches that Morris still suffers from began then. All through his 30s Morris had periods of depression and ideas of suicide. From age 37 on he took steady doses of enough hormones to change his anatomy so he could pass as female. At age 45 he underwent surgical transformation.

Nothing in this case history, abstracted from the narrative, is startling or specific. Perhaps we are chasing a will-o-the-wisp, for what is gender? Morris states that she never thought the conundrum of gender emanated from the male sex organs.

> To me, gender is not physical at all, but is altogether insubstantial. It is soul, perhaps, it is talent, it is taste, it is environment, it is how one feels, it is light and shade, it is inner music, it is spring in one's step or an exchange of glances, it is more truly life and love than any combination of genitals, ovaries, and hormones. It is the essentialness of oneself, the psyche, the fragment of unity.

In this sense gender is a psychological abstraction to be distinguished by both environment and biology. Without making these distinctions herself, Morris gives us examples of these different aspects. After the surgery, she reports, "The more I was treated as a woman, the more woman I became."

At the same time she noticed the following psychological changes, which she relates to the loss of male hormones and genitalia:

> Psychologically I was distinctly less forceful. A neurotic condition common among women is called penis envy, its victims supposing that there is inherent to the very fact of male organs some potent energy of the spirit. There is something to this fancy. It is not merely the loss of androgens that has made me more retiring, more ready to be led, more passive: the removal of the organs themselves has contributed, for there was to the presence of the penis something positive, thrusting, and muscular. My body then was made to push and initiate, it is made now to yield and accept, and the outside change has had its inner consequences.

In her final chapter Morris comes closest to solution to the problem, without really answering the riddle.

> I have collated it [gender] with the medieval idea of soul; but I am prepared to concede that one's sense of gender may be partially acquired, as the psychologists say, or at least powerfully influenced by the state of society. Would my conflict have been so bitter if I had been born now, when gender line is so much less rigid? If society had allowed me to live in the gender I preferred, would I have bothered to change sex? Is mine only a transient phenomenon, between the dogmatism of the last century, when men were men and women were ladies, and the eclecticism of the next, when citizens will be free to live in the gender role they prefer?

Of course, by that time the concept of transsexualism will have lost its meaning and will not be recorded in the psychiatric statistics of the twenty-first century.

FRANK G. BUCKNAM, M.D.
Hartford, Conn.

Law, Psychiatry and the Mental Health System, *by Alexander D. Brooks. Boston, Mass., Little, Brown and Co., 1974, 1,143 pp., $22.50.*

This book is one of the two outstanding books in the field of law and psychiatry published in the past two years by two of the most knowledgeable professors in the field. The other is *Psychiatry and Law* (1), whose author, Prof. Ralph Slovenko, won the Manfred Guttmacher Award of APA in 1974 for it. Professor Slovenko's treatise is discursive, analytic, philosophical, and academic. It is geared for both psychiatrists and lawyers and deals with the major issues confronting the field of legal psychiatry.

Professor Brooks's volume is a magnificent treatise on the subject of law and psychiatry. It is written primarily for law students and lawyers but should be read by every serious student of legal psychiatry, including every psychiatrist who considers himself a forensic psychiatrist.

Professor Brooks has placed between two covers more material relevant to the field than ever before. He has included all of the current cases that are significant and timely. At first glance, one might notice only a collection of material that is well edited, collated, and organized. However, careful reading reveals that the organization is not just one brick piled on another; the volume is carefully cemented by an expert craftsman who introduces his subject, analyzes it well, and places each case in proper perspective.

Professor Brooks begins his presentation by introducing psychiatry and psychiatrists to lawyers. He tries to show what a psychiatrist is, how he may become involved in forensic work, and the pitfalls he may encounter in this work. He follows this introduction with a detailed discussion of the *Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. (DSM-II)* (2) under the heading, "Concepts of Mental Illness." This chapter is aimed more at lawyers than at psychiatrists. However, the sections on commitment procedures, treatment of the mentally ill, and doctor-patient relationships are important for psychiatrists.

Professor Brooks devotes most of his 1,143 pages to the

phases of criminal law as they relate to psychiatry. This is not surprising because he has taught criminal law for many years and is intimately familiar with the relationship between psychiatry and the criminal process. He covers commitment procedures and the right to treatment, with all of its ramifications. These are among the most important issues facing psychiatry today. All psychiatrists who testify at commitment proceedings or who work in hospitals treating patients ought to be familiar with the concerns raised in this section of the book, which has been effectively condensed into four major sections: The Mentally Disabled Offender, Civil Commitment, Competence (including civil competence, divorce, and child custody), and The Psychiatrist-Patient Relationship (including privilege and confidentiality).

It is impossible to pick out any particular part of this book and focus on it exclusively because the whole volume is fine. However, we may linger on Professor Brooks's treatment of criminal law because that appears to be the focus of greatest strength in the book. In his analysis of the role the psychiatrist plays, Brooks lists five major models of the insanity defense, including "no separate insanity defense as such" and abandonment of the mental condition as a factor in the offense. He also lists seven options available for dealing with the mentally ill offender; these reveal his depth of understanding of this highly complex interdisciplinary area.

This is a textbook that needs to be studied and digested; it cannot be read in a single night. The clinician would be wise to refer to it in the management of cases involving complex medical-legal issues. Brooks's bibliography in the field is exhaustive and serves as a good source of reading for any student of psychiatry and law.

This book will become the textbook for courses in law and psychiatry in the law schools of our country. It will also be used by psychiatrists teaching legal psychiatry in residency training programs. It is not a book for every psychiatrist—it is not for the beginning psychiatrist initially learning about legal problems. Rather, it is an advanced text for psychiatrists who have some familiarity with the field and wish to pursue it in greater depth. It is also for lawyers and law students who need to know how to work with psychiatrists and with clients who are involved in the mental health system.

It is obvious that Professor Brooks has spent many years compiling, organizing, analyzing, and writing this material for us. We are indebted to him for this most helpful, comprehensive volume, which will serve as the basis of our study of legal psychiatry for many years. I congratulate Professor Brooks for this scholarly masterpiece and thank him for giving us this helpful reference work.

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ROBERT L. SADOFF, M.D.
Jenkintown, Pa.

They Chose Honor: The Problem of Conscience in Custody, *by Lewis Merklin, Jr., M.D. New York, N.Y., Harper & Row, 1974, 235 pp., $8.95.*

This is a book about Selective Service resisters who were sentenced to the Federal Correctional Institution at Lompoc, Calif., during the Viet Nam War. Dr. Merklin is a young psychiatrist who was working at Lompoc to satisfy his own Selective Service requirement as an officer in the U.S. Public Health Service. He took advantage of the situation to organize a group of draft resisters so that he could both learn more about them and support them throughout their incarceration.

Dr. Merklin provides close-up character sketches, in the resisters' own words, of six of these men. Most of the book, however, is made up of transcriptions of the weekly group sessions that were taped for later study. This technique provides a fascinating glimpse of the private thoughts and motivations of these men as they coped with the custody of a federal prison. (These men were denied access to the rehabilitation programs provided to other offenders.)

It is clear from these accounts that these men were men of conscience regarding the war and the draft; they were not draft dodgers. Dr. Merklin's group sessions appear to have provided considerable support to most of the men, but they may also have precipitated some extra stresses and resistances in some of the latecomers and those in prison for a short term. The transcriptions of the group sessions are intriguing to read.

Overall, although this book is about draft resisters, it is obviously written by a prison resister. Prisons are undoubtedly antitherapeutic, but Dr. Merklin's text is an unremitting blast at the Federal Bureau of Prisons and, more especially, Lompoc Prison itself—its staff and its officials. The starkness of the system might be even more obvious without the shrillness of Dr. Merklin's language. His suggestion that prisons abandon any pretense at correction or rehabilitation and concentrate solely on punishment and custody for a small number of incorrigible individuals makes good sense. Corrections and rehabilitation could then be carried out in community mental health treatment and rehabilitation programs.

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The Nature of Human Consciousness: A Book of Readings, *edited by Robert E. Ornstein. New York, N.Y., Viking Press, 1974, 509 pp., $15.00.*

Ornstein obviously likes loose ends: a host of them are presented in this selection of 41 readings from books and articles on the nature of human consciousness. Except for two pieces by William James and a smattering of readings from the 1940s and 1950s, the readings are from the past two decades, particularly from the last few years.

For a scientific and professional world tied up in tight knots of logical thinking, this book is an enlightening, timely presentation of the other side of consciousness—stuff that seems to come mainly from the right side of the brain. It is stimulating and provocative, although uneven. While a book on consciousness can hardly avoid the unconscious, there is no separate reading in this volume on the relationship of consciousness and the unconscious.

Any reader digesting this sampling will have his appetite satisfied and come away with a renewed respect for the scholarly advances in thinking, theory, therapy, and research in consciousness. The bias that inevitably exists in any selection of readings is, I think, conscious, but the main shortcoming I see in this book is the lack of classical selections. Jung's article on what he termed "synchronicity" is hardly his best or most appropriate work on the psychology of consciousness, although it does fit admirably into the scheme of the section titled An Extended Concept of Man. There is only one brief selection by a psychoanalyst and none by Freud.

The editor has written continuities for the seven divisions of the book. I only wish that he had written more. To me, the best of the selections, in order of their presentation in the book, are the following: Polanyi on "Understanding Ourselves," Blackburn on "Sensuous-Intellectual Complementarity in Science," Deikman on "Bimodal Consciousness," Bogen on "The Other Side of the Brain: An Appositional Mind," Hastorf and Cantril on "They Saw a Game: A Case Study," Neisser on "Processes of Vision," Deikman on "The Meaning of Everything," Whorf on "Language, Mind, and Reality," Assagioli on "Psychosynthesis: A Technique for the Use of Intuition," Luce on "Biological Rhythms," LeShan on "What Is Important About the Paranormal," and Tart on "Preliminary Notes on the Nature of Psi Process."

The reader's curiosity will be rewarded by the articles on biofeedback, air ions, meditation, perception, and the split brain. The readings on Zen, Sufism, Gestalt, and structural integration are disappointing.

In the introduction, Ornstein quotes Abraham Maslow: "If the only tool you have is a hammer, you will tend to treat everything as if it were a nail." This is a wise aphorism, and an appropriate one for the editor of this volume, who has a whole bag of tools that he shares with his readers. It seems to me that his criterion for selection of articles for this volume was the germ of "untrammeled imaginative thinking" (after Herrick). This is a book for those who want to be more aware of awareness.

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Schizophrenics in the New Custodial Community: Five Years After the Experiment, *by Ann E. Davis, Simon Dinitz, and Benjamin Pasamanick. Columbus, Ohio, Ohio State University Press, 1974, 206 pp., $12.00.*

This book is written with such clarity and honesty that it is a delightful experience to read it, particularly after many years of reading the literature on schizophrenia, which is more often difficult and not easily understood.

The authors, two sociologists and a psychiatrist, present the data, evaluations, and conclusions derived from a seven-year study of the lives and experiences of over 100 carefully diagnosed chronic schizophrenic patients.

This interesting work is a five-year follow-up of the original study, which began in 1961 and ended in 1964 and is reported in a book titled *Schizophrenics in the Community* (1). The high standing of the authors of the original work and their research studies is evidenced by their receiving the Hofheimer Prize of APA in 1967. Two of the authors of the original study, Dinitz and Pasamanick, are coauthors of the follow-up volume.

A few comments about the original study are in order, since this book review concerns the same patient population. The original study demonstrated that acutely psychotic patients could be treated at home at least as well as in hospital facilities, thus eliminating the need for hospitalization, and that this could be done with a minimum of psychiatric and other professional personnel. The treatment plan consisted of home visits by public health nurses; they provided medication prescribed by a project psychiatrist, who held office consultations with the patients at prescribed intervals.

The authors of the follow-up volume state that studies such as these two are not only rare but almost unprecedented, that no other studies have dealt exclusively with a homogeneous diagnostic population such as schizophrenic patients, that none have been followed for so long (five years), and that none have selected patients exclusively from public facilities.

For anyone interested in long-term patients, this book is full of excellent case histories, from which a number of simple but important and far-reaching conclusions are inevitable. The most noteworthy is that, by the use of a little more common sense plus sociological supports and continuing medication, the results of care and treatment for schizophrenic patients would be vastly improved—with a long-term diminution of financial and social costs. The unique contribution of this study is in its emphasis on the absolute requirement that there be continuing surveillance and treatment of former hospital patients in the community. If we fail to provide these elements, we will have merely moved schizophrenic patients from the hospital to the "back wards" of their homes and communities.

It is possible in a review only to convey suggestions of the unusual quality and profound implications of this unique book. It should be of great value to psychiatrists, psychologists, social workers, and nurses, all of whom are concerned with the diagnosis and treatment of schizophrenic patients. Medical educators and researchers, too, will find it a fine reference book. Finally, I would recommend it as required reading for all those who are in a position to influence large national sociopolitical institutions. I say this because changes in these institutions might significantly influence the type and locus of treatment for the world's most common mental illness—schizophrenia.

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Measurement and Classification of Psychiatric Symptoms: An Instruction Manual for the Present State Examination and Catego Program, *by J.K. Wing, J.E. Cooper, and N. Sartorius. New York, N.Y., Cambridge University Press, 1974, 228 pp., $14.50.*

One of the most frustrating problems in psychiatry is communication among practitioners. When you and I talk about schizophrenia, are we talking about the same thing? We may think so, but how can we be certain?

Questions such as these have, of course, bedeviled theoreticians and philosophers in every area of science for as long as science has been around. The questions are still unsettled. On a practical level, however, many of the sciences as well as the other medical specialties have forged far ahead of psychiatry. In the absence of quantitative tests and clear definitions for the syndromes with which we deal, we often have to assume (and hope) that we are all talking about the same thing when we discuss recognition, treatment, prognosis, and etiology. Some of us inexplicably seem to take pride in our difficulties in making systematic distinctions among different types of patients.

There are, however, researchers who have recognized the importance of clear, careful diagnostic categories. Without such categories there can be no testing of general theory, no evaluation of the effectiveness of treatments, and little transfer of knowledge gained from the treatment of one patient to treatment of the next similar one.

Efforts to put diagnosis on firmer footing have taken several directions. First has been standardization of the process of data collection upon which diagnosis is based—for the most part, the mental status examination. Second has been the precise defin-

ing and fixing of diagnostic categories and the rules for assigning patients to these categories. Third has been the comparison of day-to-day diagnostic practices of clinicians.

For the past few years, a number of groups in scattered locations around the world have engaged in efforts in all three directions. Outstanding among these groups has been the one headed by John K. Wing at the Medical Research Council Social Psychiatry Unit, Institute of Psychiatry, London. For some time Wing and his collaborators have been working to develop a standard psychiatric interview and diagnostic process. This has resulted in the Present State Examination (PSE) and its associated diagnostic scheme and computer program (Catego). This book presents the latest (ninth) revision of the PSE, its supporting documents, some history of the work involved, and descriptions of studies of reliability, validity, personnel training, and use.

The book thus contains a good deal of detail. About half of the pages are taken up with a glossary and appendices. The chapters are brief and almost telegraphic in style. Clearly, the book is essential for those using or considering the use of the PSE system.

However, much of the space devoted to the technical material about the PSE is not wasted for those who do not use the system. Anyone seriously concerned about problems of diagnosis—from either the researcher's or the clinician's viewpoint—will find here precise definitions of symptoms with examples and instructions for probing during the interview. The detail given in this book goes far beyond what is available in any other single source. Although not primarily intended as such, this book can be used as a supplementary text or reference for courses in psychiatric interviewing and diagnosis. If widely adopted, it could represent a major force for improvement in the quality of mental status examinations, which are frequently sloppily performed even in the best training centers.

The authors make the point several times that the PSE system is derived from a European style of psychiatric interviewing. They criticize the approach they consider typical of the "American style," which they feel is exemplified by the work of Spitzer and associates (1). Although they agree that Spitzer and associates have gone far beyond the traditional, almost structureless psychiatric interview, they write that the Psychiatric Status Schedule (PSS) of Spitzer and associates shows a "selection of items" and a "relative lack of interest in the details of psychopathology, particularly in those that might be of diagnostic importance." Wing and associates also write that the PSS is "American rather than European in style."

Thus with a flick of the wrist they seem to dismiss the diagnostic work of American psychiatrists. No doubt, we deserve some castigation; diagnosis has been sadly neglected in the United States. But perhaps their dismissal is a little too broad. For example, the impressive series of papers and the recent book (2) from the group at Eli Robins' Department of Psychiatry, Washington University, St. Louis, Mo., deserve some recognition.

Furthermore, although a major step forward in technique, the PSE itself is built on the shaky foundation of traditional diagnosis. The authors are no doubt aware of this, but they neglect to mention the undemonstrated validity of most of our standard diagnostic categories, the possible confounding effects of examiner bias and examiner-patient social class differences upon the diagnostic interview, the possibility that many crucial symptoms are transient and represent responses to environmental stress, and, finally, that much of the interaction between examiner and patient, and therefore the outcome of the diagnostic interview, may be influenced by extraneous social pressures and social roles of which we are only now becoming aware. To be sure, the authors cannot be asked to take on all of the problems of modern psychiatry in one brief volume, but their certainty of their own approach does seem to call for some acknowledgment of unanswered questions.

On the whole, there is a great deal in this book that is very useful. Every serious student of psychiatric diagnosis should study it, and every person learning to do mental status examinations should be aware of the descriptions and probes of symptoms that are presented in this volume.

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Psychiatric Residency in Service Settings, *edited by Van Buren O. Hammet, M.D., and Norris Hansell, M.D. Hillsdale, N.J., Town House Press, 1973, 121 pp., no price listed.*

In recent years the need to carry psychiatric treatment to members of ethnic and socioeconomic groups identified as disadvantaged has been stressed. Many leading psychiatrists complain that although adequate psychiatric effort has been directed toward the upper classes, inadequate effort—primarily by state hospitals and similar tax-supported institutions—has been directed toward the disadvantaged. This criticism is imbedded in the matrix of the broader social and political assertion that treatment of illness is not a privilege but a right that must be made as freely available to those who cannot pay as to those who can. These psychiatric leaders also aver that a disadvantaged person who needs treatment but does not recognize that need should be so approached as to apprise him of his need and to induce him to accept treatment.

Those who conduct psychiatric residency programs realize that this major change in the emphasis of psychiatric practice demands that they change their programs to teach attitudes, knowledge, and skills appropriate to the treatment of the disadvantaged. Some educators have wondered whether their middle-class background prepares them to deal with the value systems and lifestyles of the disadvantaged groups they propose to reach. Others have feared that the middle-class background of the resident himself would erect further obstacles.

However, a number of psychiatric teaching centers addressed themselves to these problems and began to design training programs that emphasize treatment of the disadvantaged. In doing so, many of them assumed that the locale of treatment would be the community mental health center or some analogous organization placed functionally, if not geographically, in the community to be served. These programs have been activated. In the course of consequent academic operations, these centers have accumulated an array of varied experience. This book reports a meeting held to compare notes among the various programs.

During "three days in June of 1972, a group of 26 men met, at a lodge high in the Rocky Mountains, for the purpose of having a series of discussions." The group included chairmen of departments of psychiatry, program directors, residents, and others involved in mental health care. The discussion oriented itself to the five following objectives: 1) mental health care should be accessible within a single system, 2) it should deal promptly

with emergencies and crises, 3) it should serve people in need whatever their diagnosis or prognosis, 4) it should be given without regard to the patient's ability to pay, and 5) it should be responsive to the needs of society as well as the needs of the individual mental patient.

A special objective of the conference was to find "ways of modifying the traditional methods of training in order to prepare the trainee . . . in carrying forward . . . changes in the practice of psychiatry."

Each of the representatives of five training programs described the philosophy and approaches of his program and reacted to discussion of that program by both formal discussants and the conference at large. Each presenter told "how we do it, why, and how it seems to be working." The other conference participants underscored useful ideas in the presentations and expanded from them in their discussions.

This book contains valuable and helpful information for those conducting psychiatric residency programs, especially those attempting to increase emphasis on work in the community and the use of service activities for teaching purposes.

The book also has value for the nonacademic psychiatrist who wants to improve his own effectiveness with disadvantaged persons or to apprise himself of current thought in this area. It will help residents orient themselves in today's psychiatry. It also contains insights for members of such allied professions as clinical psychology, psychiatric social work, and psychiatric nursing.

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Drinking, Community and Civilization: The Account of a New Jersey Interview Study. Monographs of the Rutgers Center of Alcohol Studies 9, *by Harold Fallding, with the assistance of Carol Miles. New Brunswick, N.J., Rutgers Center of Alcohol Studies, 1974, 69 pp., $6.00.*

This volume is slender but excellent. Professor Fallding is a distinguished sociologist whose major interests have been sociological theory, religion, the family, and, more recently, alcoholism. Carol Miles is identified as a doctoral candidate "who bore the main load of assistance."

Readers who are not fluent in sociologese must be prepared to have some initial difficulty with certain key words in this book, words that appear familiar but are used in an unfamiliar way. For example, Fallding identifies four types of drinking in the following terms:

Ornamental. Symbolic of community (human or supernatural), thus benign, social, ceremonial, religious, or sacred. This is called normal.

Facilitation. Designed to ease integration into society in the face of internal barriers, thus to compensate for and counteract blocks and inadequacies. This is called a crutch.

Assuagement. Using alcohol as a substitute for community, a gratification for those with no social membership. This is called glitter behavior; alcohol is used as food, power, excitement, or possessions; or mystical exaltation may be used.

Retaliation. Protest drinking, exploiting the incapacity of being on skid row in revenge at the system. This is called partial suicide.

Fallding's typology for abstinence relies upon opposition to the above types of drinking: indifference abstinence, in opposition to ornamental drinking, considers drinking unnecessary and redundant; moral abstinence, in opposition to facilitation drinking, considers drinking an irresponsible forfeiture of self-control; religious abstinence, in opposition to assuagement drinking, considers religion rather than alcohol to be the answer to social demoralization; and respectability abstinence, in opposition to retaliation drinking, which considers that drinking produces low-status bums and drunks.

Fallding includes a masterly chapter on the history of drinking practices in New Jersey over the past four centuries, with special attention to the great American adventure of Prohibition. He reasons,

> If drinking has to be categorically outlawed because many abuse it, the impression can be left that all drinking is an abuse . . . . It is a crucial problem of this study to ask what sense of meaningfulness in drinking has been recovered by modern Americans in view of history.

Fallding set about the task of determining why people drink or abstain from drinking by sending out carefully coached interviewers to semirural burroughs in New Jersey to question over 300 individuals. Anyone interested in shrewd, sophisticated questioning in the field of alcoholism would do well to examine the interviewing schedules used. (These are not printed in the book, however. They are available by writing to a source whose address is given in a footnote in the text.)

Fallding concludes that people are divided fairly evenly in their attitudes toward drinking. About half of his sample considered drinking to be relaxing, pleasurable, and an aid to sociability, and about half considered it to be a danger that leads toward loss of control, accidents, and habituation or addiction. There was a positive relationship of favorable attitudes toward drinking with affluence and influence and a negative relationship with religious observance.

In answer to the book's central question of what is the significance of drinking or abstaining, Fallding found that 83 percent of all drinkers could be categorized as drinking for facilitation, 65 percent as ornamental drinkers, 14 percent as assuagement drinkers, and none as retaliation drinkers. There was considerable overlap among these categories. Fallding concludes that the most significant finding of the study was the general prevalence of facilitation (relaxation) drinking.

Among those who did not drink, 61 percent were moral abstainers (in opposition to facilitation drinkers), 38 percent were indifferent, 34 percent were religious, and 20 percent were respectability abstainers. Both drinking and abstaining were family related and strongly dependent on parent-child or husband-wife relationships.

The authoritative national survey of drinking practices in the United States was published in 1969 (1), the year Fallding reports that his survey was completed. The general correspondence between the two studies is striking and of great confirmation value. One must be clear, however, on just what is confirmed—not that drinking is good for you, but that many people (as many as do not) think it is. At least they like and approve of the effects of drinking.

Anyone with a professional or scholarly interest in the problems of drinking and alcoholism will enjoy this little book. Sip it slowly.

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PHILIP SOLOMON, M.D.
SUSAN T. KLEEMAN, M.D.
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Drug Dependence: Social Regulation and Treatment Alternatives, *by Carl N. Edwards. New York, N.Y., Jason Aronson, 1974, 193 pp., $7.50.*

This book was originally published in 1973 under the title of *Justice Administration and Drug Dependence: Issues and Alternatives* (now out of print). The original title is longer and more descriptive of the contents. It is a thoughtful book whose audience may be a larger group of professionals and laymen interested in the problems of addiction than only psychiatrists.

Concerned with the increasing incidence of drug abuse, the author and his collaborators first point out the widespread nature of the problem. They then demonstrate the highly contradictory attitudes that exist in relation to drug use, degree of illness, and adequacy of treatment.

The chapter titled "Psychiatry and the Law" is very good. This essay is well worth reading—even by psychiatrists who deal regularly with the courts. It presents a good summary of important legal decisions and a view of the psychiatrist's role in the legal process.

The difficulty in defining addiction is no surprise to the practicing psychiatrist who struggles throughout his professional life with the attempt to define such states as normal, psychosis, psychotherapy, and the like. Too broad an overview tends to blur out the concepts on which there is general agreement. I know that this may sound carping, but the nonprofessional may be bewildered by this book's overstatement of the controversies.

The chapter titled "Treatment Alternatives" explores the medical model and the self-help abstinence model in a lively way. Emphasis is placed on the need for mutual understanding among the helping professions as well as in the judicial system.

The restatement of the dilemmas in the field of addiction is scholarly. The attitude of horror of stereotype and generalization is evident, but by moving to an opposite polarity the book may disappoint the reader who is looking for a more positive statement.

I feel that this book is a worthwhile contribution, carefully researched and including an excellent bibliography.

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Some Must Watch While Some Must Sleep, *by William C. Dement. San Francisco, Calif., W.H. Freeman and Co., 1974, 139 pp., $5.95.*

This trim, attractive volume does not fit into the category of works ordinarily reviewed in a professional journal. Originally written as one volume in the Portable Stanford series, it is directed primarily at the intelligent lay reader who wants to become informed about the subject of modern sleep research. However, it covers much more than the findings of sleep research.

By intent, it is a highly personal description by Dr. Dement of the fascinations, trials, pitfalls, triumphs, and challenges of sleep research. Thus it tells not only about sleep but about science and what it is like to be a scientist. Designed as well as written by Dr. Dement, who selected the title from Shakespeare and the illustrations from Picasso's work, the book reveals a great deal about Dr. Dement as a human being: decent, wise, concerned, sensible, subject to the ubiquitous human foibles, but always deeply curious and in active pursuit of knowledge. A reader unfamiliar with sleep research will come away not only informed about its subject matter but with a sense of the excitement of science and a stimulus to join its ranks. For these reasons the book has special value for young people.

This is not to suggest that Dement fails to provide sufficient information about sleep itself. Quite the contrary, he covers a variety of issues in the most important areas of sleep research: its nature and functions, sleep deprivation, dreaming, and sleep disorders. Necessarily, the coverage is far from exhaustive and not even comprehensive. It is intended literally only as an introduction to the topic. However, the book has an accuracy and authenticity that only a preeminent authority can provide, so that although the reader gets an incomplete view, it is not a distorted one.

The lack of coverage is greatest in the area of basic biology, e.g., biochemistry and neurophysiology. The appendix provides a bit more detail in these fields as well as a glossary of relevant technical terms and a "reader's guide" that suggests multiple sources for obtaining further information. The lattermost is helpfully classified as to the complexity and content of the sources.

Stylistically, there are occasional problems of two opposite varieties. The usually successful emphasis on clarity and comprehensibility sometimes becomes sufficiently labored to seem condescending. In his conscious effort to be personal and informal, Dement occasionally strays past the border of charm. Conversely, highly technical medical terms and concepts are sometimes used without explanation when they are not directly related to the area of sleep research. Dement succeeds overall, however, in making his book interesting, stimulating, highly informative, eminently readable, and within the compass of the intelligent layman.

This, then, is not a book for the psychiatrist or for the psychiatric resident, who will do better to use a more sophisticated, content-oriented source. But it can be recommended with enthusiasm to the premedical or fledgling medical student, to the intelligent layman, and to the very bright high school student. For such an audience it will provide a superb introduction to knowledge about sleep as well as an exciting insight into psychiatric research.

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Marital and Sexual Counseling in Medical Practice, *2nd ed., edited by D. Wilfred Abse, M.D., Ethel M. Nash, M.A., and Lois M.R. Louden, Ph.D. New York, N.Y., Harper & Row, 1974, 558 pp., $14.95.*

This book is the second edition of the pioneering work of 1964 that was aimed at educating and training medical students and their teachers as well as physicians and their paramedical associates in the practice of total medicine. This goal is approached by emphasizing the distillate of clinical experience that attitudes as well as anatomy must be heeded in giving counsel about marriage and sex and that, although organic disease may cause marital problems, the reverse is also true.

The revision of this book is timely and even urgently needed because substantive developments have occurred in the field in the very short period of 10 years. Outstanding, of course, is the work of Masters and Johnson with their landmark publication in 1966 (1), which is foremost among several other contributions to this period of sexual revolution. A synthesis of recent work is reflected in the pages of this edition of *Marital and Sexual Counseling in Medical Practice.*

To the well-read psychiatrist, there will not be so much that is new or in depth in this book. However, for those psychiatrists involved in teaching practitioners in continuing education pro-

grams, medical students, residents, and paramedical personnel, this book can be invaluable in presenting concepts at the level of the student and avoiding psychiatric terminology. Unfortunately, the book has been put together by the editors; its various chapters are written by different contributors. Although the individual contributions are outstanding, the book lacks the impact and unity of a single-authored volume. Thus it functions more as a reference book than as an internally consistent how-to-do-it guide for those confronted with clinical material in daily practice.

The first edition of this book played a considerable role in adding studies of sex and marriage to medical school curricula. It is likely that this edition will continue to further this worthy cause because it insists that members of the medical profession must meet the public's expectations. Physicians must acquire and teach each other the skills they are expected to possess in the area of marital and sexual matters.

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PETER A. MARTIN, M.D.
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The History of the Concept of Association of Ideas, *by David Rapaport. New York, N.Y., International Universities Press, 1974, 189 pp., $8.50.*

"I think about thought," Edward Dahlberg wrote. "Believe me, there's no more cruel labor than that, for no matter how hard you think you are likely to be thoughtless" (1, p. 82). This is so despite the fact that the most earnest of men, from Plato and Aristotle to Russell and Chomsky, have thought about thought, not thoughtlessly but without end. David Rapaport's posthumously published *The History of the Concept of Association of Ideas* is witness to the cruel labors involved in thinking about thought.

The work calls for a tripart treatment: as the initiate product of a man who in his lifetime gained recognition and respect as a distinguished psychologist, esteemed for his deep erudition; substantively for its succinct exposition of the thoughts of nine of the leading philosophers, from Descartes to Kant, preoccupied with thought processes and the role therein of the association of ideas; and for its relation to present-day thought on association.

The text of this work is the doctoral dissertation that Rapaport submitted in 1929 to the faculty of the University of Budapest. The text shares the common characteristics of the doctoral dissertation. Addressed to the learned faculty, it is the novitiate's offering to the cognoscenti to show that the candidate knows what the faculty intends him to know. This submission presumes a two-sided familiarity with the material that is not necessarily shared by the outside reader. In such cases the reading may prove a bit taxing.

The work can be read as academic biography. As such, it reveals its author to have been a broadly informed and critical-minded young man. He was not content to merely expound what the philosophers (Bacon, Descartes, Hobbes, Spinoza, Locke, Leibnitz, Berkeley, Hume, and Kant) wrote and thought about thought, particularly about the role therein of the association of ideas, but further evaluated the philosophers' basic postulates and derivative conclusions. He opined freely and firmly on the contributions and limitations of the cited authors with an assuredness that evokes admiration. That assuredness characterized his personality and his other works.

Twenty-one years after he wrote this history of association of ideas, Rapaport published a monumental work quite in the spirit of his doctoral thesis, *Organization and Pathology of Thought* (2). In this later book he canvassed the writings of the leading European and American psychologists and psychiatrists, selecting and, where necessary, translating pertinent segments of their publications. To this survey he added 40 pages of conclusions. His final sentence characteristically affirms,

> It would seem that, after the many attempts to explain [thinking and] thought-disorders by a simple theory have proved partial or irrelevant, this complex phenomenon will finally exact a complex definition." (2, p.730)

This is judicious assuredness.

The authors discussed in *The History of the Concept of Association of Ideas* were essentially philosophers. None of them, with the possible exception of Descartes, was also an experimentalist. Yet it was experimental psychology, a late development, that yielded the most serious challenge to the association theory. The work of Pavlov on the conditional reflex and Kurt Lewin's studies on the motivation of thought (i.e., thinking and reasoning do not happen by themselves) stand forth in critical opposition to the classical theory of association. Yet, as George Humphrey (3) stated, "The history of the psychology of thinking consists largely of an unsuccessful revolt against the doctrine of association" (p. 28).

In this purview, and for its biographical relevance, this earliest of Rapaport's works has a many-sided appeal and significance.

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1. Dahlberg E: Confessions. New York, George Braziller, 1971
2. Rapaport D (ed): Organization and Pathology of Thought: Selected Sources. New York, Columbia University Press, 1951
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Textbook of Adolescent Psychopathology and Treatment, *by Adrian D. Copeland, M.S., M.D. Springfield, Ill., Charles C Thomas, 1974, 135 pp., $9.75; $6.95 (paper).*

This is a brief, concise, and highly readable text. In keeping with the title Dr. Copeland divides the book into two main sections, the psychopathology of the adolescent and his treatment. Included in the section on psychopathology is a brief discussion of key factors in the psychological evaluation of normal adolescents. This is followed by a discussion of basic concepts in and classification of adolescent psychopathology.

The second section of the book is devoted to treatment and includes three chapter headings: "Treatment of the Adolescent," "Aspects of Psychotherapeutic Technique," and "Education, Vocation and Adaptation." The author places great stress on the special adaptational problems of emotionally disturbed young people and offers proposed solutions to the problem of adolescent adaptational arrest.

Readers who look for case reports to document texts on treatment will be disappointed because Dr. Copeland includes no more than one or two. This inadequacy is more than compensated for by the voluminous bibliographies at the end of each chapter, however.

This book should be of value not only to psychotherapists of the various mental health disciplines but also to pediatricians working with adolescents.

CAROLINE A. CHANDLER, M.D.
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Occupational Stress, *edited by Alan McLean, M.D. Springfield, Ill., Charles C Thomas, 1974, 105 pp., $9.75.*

This fascinating volume is a distilled report of a seminar on occupational stress held in 1972 in White Plains, N.Y., by the Westchester Division of New York Hospital-Cornell Medical Center. Dr. McLean does a superb job of reporting the mass of material generated by representatives of occupational medicine, psychiatry, psychology, psychoanalysis, sociology, business, industry, social work, rehabilitation, the military, and government agencies.

The concept of stress is controversial. It is not readily or universally defined or understood and is difficult to measure. There are many communication gaps among the disciplines interested in occupational stress specifically.

From the major presentations and the group discussions, Dr. McLean chose the following topics for chapter headings: "Occupational Stress and Strain," "Clinical Concepts," "A Psychoanalytic Framework," "Stress, Distress, and Psychosocial Stimuli," "Conflict, Ambiguity, and Overload: Three Elements in Job Stress," "Role Responsibility: The Differentiation of a Concept," "Person Role Fit," "Health Status Assessment: An Untapped Source of Management Information," "Work Performance and Occupational Stress," and "Off-the-Job Stress and Occupational Behavior." Dr. McLean also contributed two chapters, "Concepts of Occupational Stress" and "Occupational 'Stress'—A Misnomer."

It is clear from Dr. McLean's summary that the term "stress" as used by behavioral scientists, clinicians, and engineers has different meanings. Most clinicians consider stress to be an external force that produces symptoms in patients. Many researchers consider stress to be the result of an external stressor or, in Selye's terminology, a general adaptation syndrome. Engineers and some behavioral scientists view stress as an internal product of external loading.

When the term "stress" is applied to behavior on the job, its different meanings interfere with clarity of communication and understanding across disciplinary lines. This book presents the most widely held concepts of occupational stress in a single volume. Theoretical concepts, research results, and specific suggestions for coping with stress-related problems are included. Psychiatric, psychoanalytic, and psychophysiological considerations are discussed as well as ideas from role therapy.

Among the many revealing ideas in this volume are the following:

1. Companies might add a human resources section to their annual reports, assessing their ability to meet workers' needs for job satisfaction as part of their accounting system.
2. Job stress represents a poor person-environment fit.
3. Job stress is caused by a factor or group of factors (job stressors) that disrupt psychological and physiological homeostasis, creating job strain. Five groups of dimensions of such factors are measurable: anxiety, tension, and anger; chronic depression, fatigue, alienation, and general malaise; the level of catecholamines, blood lipids, blood pressure, and gut motility; gastrointestinal disorders, coronary heart disease, asthmatic attacks, and other psychosomatic disorders; and decrease in work performance.
4. The mental set of the worker at the time of job stress is important. Coping with it includes casting out stress, substituting vicarious stress for real situations (spectator activities), physical activity, recreation, fitting natural biologic rhythm to job environment, and discovering workers' desires, proclivities, and interests.
5. Work behavior can be viewed psychoanalytically in terms of drive or instinct theory, id, ego, and superego structure, levels of consciousness, the developmental concept of personality, and concepts of adaptation between these forces and the environment. Psychological sources of disruption involve fear, guilt, and anxiety tolerance. Adaptation involves coping with character defenses.
6. Off-the-job stresses might be reduced by reopening day-care centers for mothers who are working, by offering job retraining to workers who request it, and by supporting improvements in the general physical environment (e.g., working toward anti-noise legislation and pension protection).
7. Since our knowledge of psychosocial hazards and diseases is fairly incomplete, much of what we say about monitoring and preventing disease is incomplete.

Dr. McLean concludes that stress should be considered a general rubric rather than a single concept. He states,

> Each discipline must further develop its own terms to refer to the specific concepts of its own analysis. The presentations of each researcher and clinician must define his frame of reference and his terms in such manner as to be intelligible to those in his professional audience unfamiliar with what has gone on before in his discipline. Clarity, definition ... exposure, cross-pollination, and acceptance of those differing concepts as deeply held values is urgently necessary if we are to further our task.

I agree completely and recommend this volume.

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Operational Theories of Personality, *edited by Arthur Burton. New York, N.Y., Brunner/Mazel, 1974, 414 pp., $15.00.*

The purpose of this book is to describe a broad array of personality theories, making their ties to clinical practice explicit (or operational). To achieve this end, the editor has sought contributions from the founders of the various theories. Thus the chapters on client-centered therapy, rational-emotive therapy, and bioenergetics are written by Carl Rogers, Albert Ellis, and Alexander Lowen, respectively.

When the originators of theories were unavailable, chapters were written by well-known students and associates of theorists. For example, Rudolf Ekstein writes about Freud, James Hillman about Jung, and Hilde Bruch about Sullivan. The book consists of 11 such chapters, bracketed by introductory and concluding comments by the editor. Approximately 20 percent of each chapter is devoted to a case study in which theoretical discussions are brought to life.

In creating this kind of book Burton implicitly states his willingness to sacrifice the uniformity of style and organizational consistency that result from single authorship for the wisdom, attention to detail, and anecdotal information that only such eminent authors can provide. The full potential of this approach, however, is only partially realized here.

The chapters on Sullivan, Rogers, Ellis, Skinner, and Adler are all good, straightforward, elementary accounts. However,

except for Heinz Ansbacher's Adlerian analysis of the life and death of Marilyn Monroe and Bruch's recollections of Sullivan as a supervisor, they offer little to the reader that he has not yet read or cannot find elsewhere. Most of the chapters seem to be addressed to the beginning student of personality. One looks in vain for any new theoretical statements or applications that would distinguish this textbook. Only Ekstein assumes a more sophisticated readership, largely limiting his remarks to the way in which personality changes during the course of psychoanalytic treatment. His article and Hillman's are likely to be difficult for newcomers to the field.

Burton's choice of theorists is comprehensive and often pleasantly surprising, although the inclusion of Gordon Allport seems somewhat strained. Reich and Lowen, Ellis, and the family theories of Donald Jackson and Nathan Ackerman are rarely represented in standard personality texts, although they certainly belong in a text that emphasizes clinical application. In this regard Helm Stierlin's chapter on family theory is an especially inviting and well-integrated introduction to a relatively new field that is full of diverse ideas. Burton's own chapter on Binswanger and Laing, on the other hand, gives the flavor of their theories but is so fraught with jargon that only the most devout proponents of existentialism will not protest.

As a reference book or for the practicing clinician, this book will have little appeal. The same information plus much more is, in the case of each theory included, readily available elsewhere. Further, the case applications are, of necessity, brief and predictable. However, for the beginner in personality theory, whether in psychiatry, psychology, or social work, the book houses under one roof a collection of informative if uneven introductory articles. All of them offer a basic understanding of how various theorists conceptualize personality and treat people with emotional problems.

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Experiment Perilous: Physicians and Patients Facing the Unknown, *by Renée C. Fox. Philadelphia, Pa., University of Pennsylvania Press, 1974, 257 pp., $5.95 (paper).*

This is the first paperback edition of a sociological study of a behavior research ward in a New England hospital connected with a medical school. It was originally published in hardback by Free Press in 1959 and is based on studies conducted in the early 1950s. The ward studied had 15 beds and was heavily staffed with research personnel, including 11 physicians. The research was focused on the effects of ACTH and cortisones on chronically ill patients with various diagnoses. Many other drugs were also used. Addison's disease and diabetes, particularly when they were seen in combination, were the most interesting to the researchers, but the study was by no means confined to the smaller number of patients who had both illnesses.

This is not a medical textbook. Although Ms. Fox was able to pick up a great deal of medical knowledge, much of it is now obsolete, and there are what appear to be outright errors in her understanding of medical situations. It is the earliest and still the most important sociological study of research scientists and their patients, however. It focuses on the sociological and psychological problems of both staff and patients and the surprisingly similar coping mechanisms developed by both groups.

The book is extremely interestingly written. It is a pleasure to read because it has many of the literary characteristics of a novel rather than a scientific study. This statement is not meant to downgrade the sociological and psychological qualities of the book. On the contrary, the writing style emphasizes these qualities in a way that makes them easy to remember.

The major focus of the book is the ethical problems of human experimentation as they were felt by the medical staff of a research ward. Fox carefully describes how potential conflicts were solved.

I would recommend this book to all who are involved actually or potentially in experimental work with human beings in any field of medicine or related sciences. A great deal has been written on this subject recently by scientists, theologians, politicians, and many others. However, I believe this book makes more sense than most recent publications on the subject. Unfortunately, medical-legal aspects of the problems of human experimentation are almost entirely ignored, perhaps primarily because they were less of a problem at the time this book was written than they are now.

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The Secret Strength of Depression, *by Frederic F. Flach, M.D. Philadelphia, Pa., J.B. Lippincott Co., 1974, 282 pp., $7.95.*

It is my impression that the best technique for developing clarity and precision of presentation in any type of science writing is to write ostensibly for the general public. This book, which is so written, will certainly be of great value to the medical student, the family physician, and the resident in psychiatry. The style is intriguing, absorbing, and fascinating. The compelling way the case histories fit into the lucid discussion of the historical and theoretical considerations of depression is remarkable.

This book satisfies the criteria as a source of study. It is well outlined, and the chapters unfold in an orderly fashion that seems to follow the natural history of the condition of depression. The indexing and referencing withstand very careful scrutiny. The skillful method of working into the discourse the historical perspective demonstrates again that the true scholar can inform without being pedantic or condescending. The author's comments on the multifaceted nature and etiology of depression speak well for his balanced approach as a laboratory scientist, a clinician, a clinical teacher, and a social historian.

I am sure that his book will be a source of considerable comfort to anyone whose life has been touched by depression—his own or that of significant others. It is written by a clinician whose long experience in helping people is well conveyed by his prose.

Dr. Flach not only gives the impression of understanding but, in a kindly, direct fashion, goes a long way toward dispelling further anguish by providing some definite steps to take to secure relief from depression. Most people will take some surcease from sorrow as they realize that Western man has been plagued with varying degrees of depression from prehistoric times. No matter that the physicians of antiquity thought that melancholia was black bile—they were sure it had many causes and, like today's healers, tried many cures.

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Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

Obsessive Children, *by Paul L. Adams, M.D. Baltimore, Md., Penguin Books, 1975, 276 pp., $2.95 (paper).*

The Behavioral Treatment of Sexual Problems, vol. 1: Brief Therapy, *by Jack S. Annon, Ph.D. Honolulu, Hawaii, Kapiolani Health Services, 1974, 230 pp., no price listed (paper).*

Philotherapy: A New Approach to Psychotherapy, *by I. Emery Breitner, M.D. Old Bethpage, N.Y., Institute of Human Relations Press, 1974, 105 pp., $5.95.*

The Scientific Evaluation of Drug Equivalency: Proceedings of a Colloquium, Washington, D.C., June 14, 1974, *edited by Albert N. Brest, M.D. Princeton, N.J., Excerpta Medica, 1974, 70 pp., no price listed (paper).*

Annual Progress in Child Psychiatry and Child Development, 1974, *edited by Stella Chess, M.D., and Alexander Thomas, M.D. New York, N.Y., Brunner/Mazel, 1975, 625 pp., $15.00.*

A Family Album: Portraits of Intimacy and Kinship, *by Thomas J. Cottle. New York, N.Y., Harper & Row, 1975, 203 pp., $7.95; $3.75 (paper).*

The Story of Medicine, *by Petros De Baz, M.D. New York, N.Y., Philosophical Library, 1975, 99 pp., $6.00.*

Parent Power/Child Power: A New and Tested Method for Parenting Without Guilt, *by Helen De Rosis, M.D. Indianapolis, Ind., Bobbs-Merrill Co., 1974, 230 pp., $6.95.*

Clinical Interviewing and Counseling: Principles and Techniques, *by Golda M. Edinburg, M.S.S.S., Norman E. Zinberg, M.D., and Wendy Kelman, M.S.S.S. New York, N.Y., Appleton-Century-Crofts (Prentice-Hall), 1975, 121 pp., $6.95 (paper).*

Life History and the Historical Movement, *by Erik H. Erikson. New York, N.Y., W.W. Norton & Co., 1975, 270 pp., $9.95.*

Medical Experimentation: Personal Integrity and Social Policy. Clinical Studies, vol. 5, *by Charles Fried. New York, N.Y., American Elsevier Publishing Co., 1974, 172 pp., no price listed.*

The Key to the Sciences of Man: The "Impossible" Relativity of Value Reactions, *by D.G. Garan, Ph.D., J.U.D., LL.D. New York, N.Y., Philosophical Library, 1975, 541 pp., $10.00.*

Learning Difficulties: Causes and Psychological Implications—A Guide for Professionals, *by Kurt Glaser, M.D., M.Sc., assisted by Susanne Glaser, M.S.W. Springfield, Ill., Charles C Thomas, 1974, 86 pp., $8.75.*

Marital and Family Therapy, *by Ira D. Glick, M.D., and David R. Kessler, M.D. New York, N.Y., Grune & Stratton (Harcourt Brace Jovanovich), 1974, 172 pp., $12.50.*

Growth and Change of Schizophrenic Children: A Longitudinal Study, *by William Goldfarb, M.D., Ph.D. Washington, D.C., V.H. Winston & Sons (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1975, 271 pp., $10.95.*

Trainer's Manual for Structured Learning Therapy, *by Arnold P. Goldstein. Syracuse, N.Y., Arnold P. Goldstein, Psychology Department, Syracuse University, 1974, 16 pp., no charge (paper).*

From Diagnosis to Treatment in Child Psychiatry, *by the Group for the Advancement of Psychiatry Committee on Child Psychiatry. New York, N.Y., Jason Aronson, 1974, 181 pp., $10.00.*

The Educated Woman: Prospects and Problems. Report 92, *by the Group for the Advancement of Psychiatry Committee on the College Student. New York, N.Y., GAP, 1975, 145 pp., $4.00 (paper).*

Mentally Ill Mothers and Their Children, *by Henry Grunebaum, Justin L. Weiss, Bertram J. Cohler, Carol R. Hartman, and David H. Gallant. Chicago, Ill., University of Chicago Press, 1975, 338 pp., $15.50.*

Adolescent Suicide, *by André Haim; translated by A.M. Sheridan Smith. New York, N.Y., International Universities Press, 1975, 307 pp., $15.00.*

Modification of Behavior of the Mentally Retarded: Applied Principles, *edited by Richard E. Hardy, Ed.D., and John G. Cull, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 157 pp., $12.75.*

A Handbook on Drug and Alcohol Abuse: The Biomedical Aspects, *by Frederick G. Hofmann in collaboration with Adele D. Hofmann. New York, N.Y., Oxford University Press, 1975, 315 pp., $10.95; $6.95 (paper).*

Vagotomy: Latest Advances with Special-Reference to Gastric and Duodenal Ulcers Disease, *edited by F. Holle and S. Andersson. New York, N.Y., Springer-Verlag, 1974, 237 pp., $34.50 (paper).*

Behavior Therapy and Health Care: Principles and Applications, *edited by Roger C. Katz and Steven Zlutnick. New York, N.Y.,*

Pergamon Press, 1975, 620 pp., $14.00; $8.75 (paper).

Mental Health and Going to School: The Woodlawn Program of Assessment, Early Intervention, and Evaluation, *by Sheppard G. Kellam, Jeannette D. Branch, Khazan C. Agrawal, and Margaret E. Ensminger. Chicago, Ill., University of Chicago Press, 1975, 204 pp., $11.00.*

A Season in Hell, *by Percy Knauth. New York, N.Y., Harper & Row, 1975, 111 pp., $6.95.*

Pleasure: A Creative Approach to Life, *by Alexander Lowen, M.D. Baltimore, Md., Penguin Books, 1975, 251 pp., $1.95 (paper).*

Psychopathology: The Science of Understanding Deviance, *2nd ed., by James D. Page. Chicago, Ill., Aldine Publishing Co. (Aldine/Atherton), 1975, 495 pp., $14.75.*

Consumers and Social Services, *by Robert Perlman. New York, N.Y., John Wiley & Sons, 1975, 123 pp., $9.95.*

Psychotherapy and Multiple Personality: Selected Essays, *by Morton Prince, edited by Nathan G. Hale, Jr. Cambridge, Mass., Harvard University Press, 1975, 328 pp., $12.50.*

The Psychoanalytic Study of the Child, Volumes 1–25: Abstracts and Index. *New Haven, Conn., Yale University Press, 1975, 414 pp., $15.00.*

Childhood Deprivation, *compiled and edited by Albert R. Roberts. Springfield, Ill., Charles C Thomas, 1974, 203 pp., $9.75; $6.95 (paper).*

The Volunteer Subject, *by Robert Rosenthal and Ralph L. Rosnow. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1975, 247 pp., $14.95.*

The Index of Scientific Writings on Creativity: Creative Men and Women, *by Albert Rothenberg, M.D., and Bette Greenberg. Hamden, Conn., Archon Books (Shoe String Press), 1974, 103 pp., $15.00.*

Compassion and Self-Hate: An Alternative to Despair, *by Theodore I. Rubin, M.D., with Eleanor Rubin. New York, N.Y., David McKay Co., 1975, 299 pp., $9.95.*

Methods of Psychiatric Research: An Introduction for Clinical Psychiatrists, *2nd ed., edited by Peter Sainsbury, M.D., D.P.M., and Norman Kreitman, M.D., D.P.M. New York, N.Y., Oxford University Press, 1975, 305 pp., $18.95 (paper).*

Self-Assessment of Current Knowledge in Psychiatry, *2nd ed., by Paul Salkin, M.D. Flushing, N.Y., Medical Examination Publishing Co., 1974, 226 pp., $10.00 (spiral bound).*

Between Existentialism and Marxism, *by Jean-Paul Sartre; translated by John Mathews. New York, N.Y., Pantheon Books (Random House), 1975, 298 pp., $10.00.*

Corporate Wives—Corporate Casualties? *by Robert Seidenberg. Garden City, N.Y., Anchor Press/Doubleday, 1975, 214 pp., $2.50 (paper).*

When I Say No, I Feel Guilty: How to Cope—Using the Skills of Systematic Assertive Therapy, *by Manuel J. Smith, Ph.D. New York, N.Y., Dial Press, 1975, 299 pp., $8.95.*

Famine and Human Development: The Dutch Hunger Winter of 1944–1945, *by Zena Stein, Mervyn Susser, Gerhart Saenger, and Francis Marolla. New York, N.Y., Oxford University Press, 1975, 274 pp., $12.95.*

The Future: Human Ecology and Education, *by Edward A. Sullivan. Homewood, Ill., ETC Publications, 1975, 151 pp., $8.50.*

Overview of the Psychotherapies, *edited by Gene Usdin, M.D. New York, N.Y., Brunner/Mazel, 1975, 204 pp., $8.50.*

Neurophysiology of Enlightenment: Scientific Research on Transcendental Meditation, *by Dr. Robert Keith Wallace. Fairfield, Iowa, Maharishi International University, 1974, 49 pp., no price listed (paper).*

Cognition and the Symbolic Processes, *edited by Walter B. Weimer and David S. Palermo. Hillsdale, N.J., Lawrence Erlbaum Associates (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1975, 442 pp., $19.50.*

Lecture Notes on Psychiatry, *4th ed., by James Willis, M.B., D.P.M. Oxford, England, Blackwell Scientific Publications (Philadelphia, Pa., J.B. Lippincott Co., distributor), 1975, 128 pp., $5.75 (paper).*

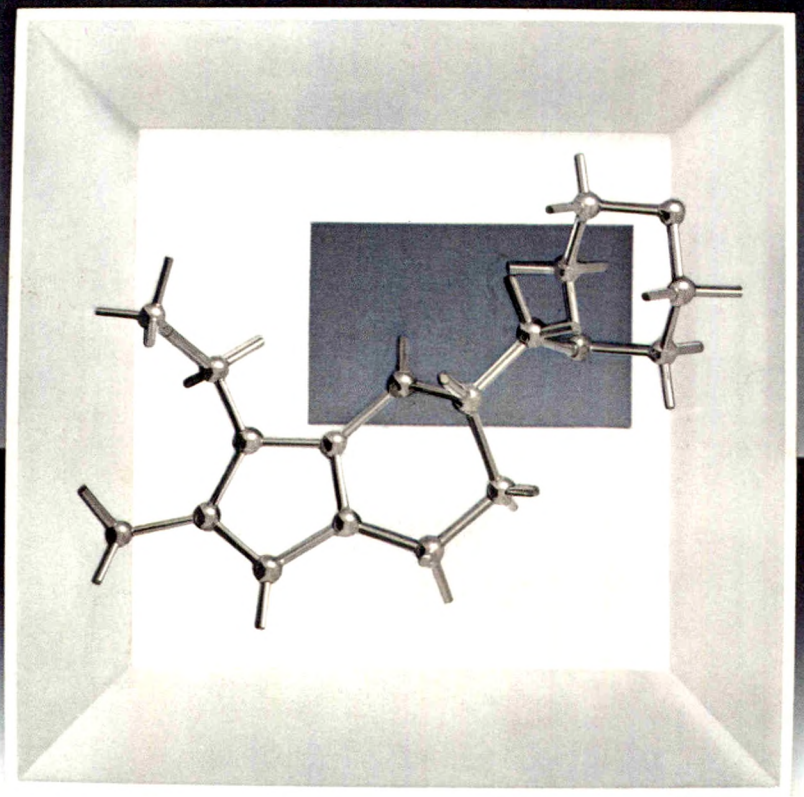
Infant and Environment: Early Cognitive and Motivational Development, *by Leon J. Yarrow, Judith L. Rubenstein, and Frank A. Pedersen. Washington, D.C., Hemisphere Publishing Corp. (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1975, 243 pp., $15.95.*

The Teenage Pregnant Girl, *edited by Jack Zackler, M.D., and Wayne Brandstadt, M.D. Springfield, Ill., Charles C Thomas, 1974, 300 pp., $12.95.*

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MOBAN® (molindone HCl) does not produce the prolonged dulling effects observed with earlier antipsychotics. This lack of continued sedation should make for a more cooperative, better functioning patient...one who will be able to assume a more active role in his over-all rehabilitation, and one less likely



ACTIVATES MANY WITHDRAWN AND APATHETIC PATIENTS

to discontinue the needed maintenance medication. A beneficial sense of well-being occurs in some patients (others may experience an abnormal, exaggerated sense of well-being).

AN EFFECTIVE THERAPEUTIC ALTERNATIVE

When patients are unresponsive or have become refractory to their current medication or suffer certain untoward side effects, MOBAN® offers a clear-cut therapeutic alternative. MOBAN® may be effectively used for the newly diagnosed schizophrenic, on a long-term, in-patient basis, or later on when the patient has assumed an out-patient status. In short, at any step on the way home.

PHARMACOLOGIC PROFILE

The pharmacologic profile of MOBAN® in laboratory animals resembles that of other major antipsychotic agents in that it causes the reduction of spontaneous locomotion and aggressiveness, suppression of conditioned psychotic responses and antagonism of the bizarre, stereotyped behavior and hyperactivity induced by amphetamines. In addition, MOBAN® antagonizes the depression caused by the tranquilizing agent, tetrabenazine.

In human clinical studies, tranquilization is achieved in the absence of muscle relaxing or incoordinating effects. Based on EEG studies, MOBAN® exerts its effects on the ascending reticular activating system.

Human metabolic studies show MOBAN® to reach peak blood levels within one hour after oral administration.

Tolerance has not developed during long-term (3 years) therapy in limited pre-introductory studies.

PLEASE NOTE: Lenticular opacities and skin pigmentation often seen with other currently-prescribed antipsychotics, have not been observed during pre-introductory studies with MOBAN®...making it suitable for those patients from whom other medication should be withdrawn due to those side effects. Such adverse effects result principally from long-term, high dose phenothiazine therapy. The possibility that similar adverse reactions may occur with MOBAN® should be kept in mind.

USUAL DOSAGE RANGES

Initial and maintenance dosages of MOBAN® (molindone HCl) should be individualized, and the minimal effective dose should be employed. Elderly and debilitated patients should be started on lower doses.

Mild 5 mg three or four times a day, up to 15 mg three or four times a day.

Moderate 10 mg three or four times a day, up to 25 mg three or four times a day.

Severe Daily dosages up to 225 mg may be required.

AVAILABLE AS TABLETS IN THREE DOSAGE STRENGTHS



5 mg 10 mg 25 mg

Reference Literature On Comparative Studies

1. Ban, TA; Ramsay, RA; Lehmann, HE: A comparative study of molindone and trifluoperazine, Curr Ther Res Vol. 12, No. 7, July, 1970 **2.** Brauzer, B and Burton, J: A clinical comparison of molindone hydrochloride with trifluoperazine in psychotic out-patients, Curr Ther Res 13: 152, March, 197 **3.** Clark, M, et al: Molindone in chronic schizophrenia, Clin Pharm & Ther Vol. 11, No. 5:680-688, Sept.-Oct., 1970 **4.** Freeman, H and Frederick, A: Comparison of trifluoperazine & molindone in chronic schizophrenic patients, Curr Ther Res Vol. 11, No. 11:670-676, Nov., 1969 **5.** Hollister, LE: Some human pharmacological studies of three psychotropic drugs: thiothixene, molindone, and W-1867, Clin Pharm Vol. 8:95-101, March—April, 1968 **6.** Itil, TM et al: Comparison of the clinical and electroencephalographical effects of molindone and trifluoperazine in acute schizophrenic patients, PDM 3:80, Sept.-Oct., 1970 **7.** Goldstein, BJ and Brauzer, B: A clinical comparison of molindone hydrochloride with trifluoperazine in psychotic out patients, Curr Ther Res Vol. 13, No. 3:152-157, March, 197 **8.** Goldstein, BJ and Brauzer, B: Comparison of molindone and placebo in anxious depressed patients, Curr Ther Res Vol. 3, No. 6:344-349, June, 1971 **9.** Ramsay, RA, et al: A comparison of molindone and trifluoperazine, Curr Ther Res 12:438, July, 1970 **10.** Rickels, K, et al: Molindone and chlordiazepoxide in anxious neurotic out-patients, Curr Ther Res Vol. 14, No. 1:1-9, January, 1972 **11.** Serafetinides, EA, Willis, D and Clark, ML: The EEG effects of chemically and clinically dissimilar antipsychotics—molindone vs. chlorpromazine, Int Pharmacopsychiat 6:77-88, 1971 **12.** Simpson, GM, et al: A double blind comparison of molindone and trifluoperazine in the treatment of acute schizophrenia, J Clin Pharmacol 11:227-236, May-June, 1971.



MOBAN®
(molindone HCl)

MOBILIZES THE PATIENT TOWARD PRODUCTIVE ACTIVITY

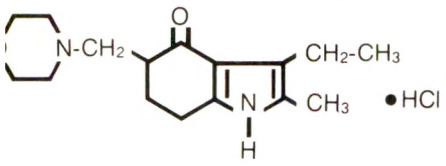
Endo Laboratories, Inc.
Subsidiary of E.I. du Pont de Nemours & Co. (Inc.)
Garden City, N.Y. 11530

DUPONT

PLEASE SEE NEXT PAGE FO
FULL PRESCRIBING INFORMATIO

MOBAN®(molindone HCl)

DESCRIPTION MOBAN® (molindone hydrochloride) is a dihydroindolone compound which is not structurally related to the phenothiazines, the butyrophenones or the thioxanthenes.
MOBAN® is 3-ethyl-6, 7-dihydro-2-methyl-5-(morpholinomethyl) indol-4(5H)-one hydrochloride. It is a white crystalline powder, freely soluble in water and alcohol and has a molecular weight of 312.67.



MOLINDONE HYDROCHLORIDE

ACTIONS MOBAN® (molindone hydrochloride) has a pharmacological profile in laboratory animals which predominantly resembles that of major tranquilizers causing reduction of spontaneous locomotion and aggressiveness, suppression of a conditional response and antagonism of the bizarre stereotyped behavior and hyperactivity induced by amphetamines. In addition, MOBAN® antagonizes the depression caused by the tranquilizing agent tetrabenazine.
In human clinical studies tranquilization is achieved in the absence of muscle relaxing or incoordinating effects. Based on EEG studies, MOBAN® exerts its effect on the ascending reticular activating system.
Human metabolic studies show MOBAN® to reach peak blood levels within one hour after oral administration.

INDICATIONS MOBAN® (molindone hydrochloride) is indicated in the management of the manifestations of schizophrenia.

CONTRAINDICATIONS MOBAN® (molindone hydrochloride) is contraindicated in severe central nervous system depression (alcohol, barbiturates, narcotics, etc.) or comatose states, and in patients with known hypersensitivity to the drug.

WARNINGS Usage in Pregnancy Studies in the pregnant patient have not been carried out. Animal reproductive studies have not demonstrated a teratogenic potential. The anticipated benefits must be weighed against the unknown risks to the fetus if used in these patients.

Nursing Mothers Data is not available on the content of MOBAN® (molindone hydrochloride) in the milk of nursing mothers.

Usage in Children Use of MOBAN® (molindone hydrochloride) in children below the age of twelve years is not recommended because safe and effective conditions for its usage have not been established.

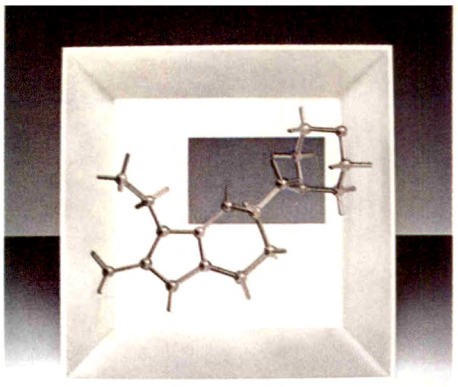
PRECAUTIONS Some patients receiving MOBAN® (molindone hydrochloride) may note drowsiness initially and they should be advised against activities requiring mental alertness until their response to the drug has been established.
Increased activity has been noted in patients receiving MOBAN®. Caution should be exercised where increased activity may be harmful.

ADVERSE REACTIONS Transient initial drowsiness was noted most frequently. Noted less frequently were Parkinsonian reactions (akinesia characterized by rigidity, immobility and reduction of voluntary movement and tremor), akathisia, restlessness, insomnia, depression, feeling of dizziness, blurred vision, hyperactivity, euphoria, dry mouth, headache, nausea and tachycardia. Upon abrupt withdrawal after prolonged high dosage an abstinence syndrome has not been noted.
Others which were observed included weight gain, weight loss, suicidal thinking, postural hypotension, initial heavy menses, amenorrhea, lactation, rash, spasticity, dystonia, akinesia, oculogyric crisis, gastrointestinal upset, increased libido, leukopenia, and nonspecific EKG changes.

ADVERSE REACTIONS NOTED WITH OTHER ANTIPSYCHOTIC AGENTS
The following adverse reactions have been observed with phenothiazine antipsychotic drugs. MOBAN® (molindone hydrochloride) differs chemically and to some degree pharmacologically from phenothiazines, but the possibility that similar adverse reactions may occur with MOBAN® (molindone hydrochloride) should be kept in mind.

Drowsiness Usually mild to moderate, may occur, particularly during the first or second week, after which it generally disappears. If troublesome, dosage may be lowered.

Jaundice Over-all incidence has been low, regardless of indication or dosage. Most investigators conclude it is a sensitivity reaction. Most cases occur between the second and fourth weeks of therapy. The clinical picture resembles infectious hepatitis, with laboratory features of obstructive jaundice, rather than those of parenchymal damage. It is usually promptly reversible on withdrawal of the medication; however, chronic jaundice has been reported. There is no conclusive evidence that pre-existing liver disease makes patients more susceptible to jaundice. Alcoholics with cirrhosis have been successfully treated with phenothiazine, without complications. Nevertheless, the medication should be used cautiously in patients with liver disease. Patients who have experienced jaundice with a phenothiazine should not, if possible, be re-exposed to phenothiazines.
If fever with grippe-like symptoms occurs, test for increased bilirubin or for bile in urine. If tests are positive, stop treatment.
Liver function tests in jaundice induced by the drug may mimic extrahepatic obstruction; withhold exploratory laparotomy until extrahepatic obstruction is confirmed.



Hematological Disorders Including agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura, and pancytopenia, though rare, have been reported.

Agranulocytosis Observe patients regularly for sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears indicate cellular depression, stop treatment and start antibiotic and other suitable therapy.
Most cases have occurred between the 4th and 10th weeks of therapy; patients should be watched closely during that period.
Moderate suppression of white blood cells is not an indication for stopping treatment unless accompanied by the symptoms described above.

Cardiovascular:
Hypotensive Effects Postural hypotension, simple tachycardia, momentary fainting and dizziness may occur after the first injection; occasionally after subsequent injections; rarely after the first oral dose. Usually recovery is spontaneous and symptoms disappear within ½ to 2 hours. Occasionally, these effects may be more severe and prolonged, producing a shock-like condition.

EKG Changes Particularly nonspecific, usually reversible Q and T wave distortions—have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.
Note: sudden death, apparently due to cardiac arrest, has been reported, but there is not sufficient evidence to establish a relationship between such deaths and the administration of the drug.

C.N.S. Effects:
Neuromuscular (Extrapyramidal) Reactions Closely resembling parkinsonism, and motor restlessness have occurred most frequently in psychiatric patients receiving high dosages. Dystonic reactions have been reported occasionally. Such symptoms usually disappear soon after dosage is lowered, the drug temporarily withdrawn, and/or concomitant administration of an anti-parkinsonism agent. (Note: Levodopa has not been found effective in relief of these neuromuscular reactions.) In severe cases suitable supportive measures such as maintaining a clear airway and adequate hydration should be used. When phenothiazine is reinstituted, it should be at a lower dosage.
Hyperreflexia has been reported in the newborn.

Persistent Tardive Dyskinesia As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.
There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.
It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Adverse Behavioral Effects Psychotic symptoms and catatonic-like states have been reported rarely.

Other C.N.S. Effects Cerebral edema has been reported.
Convulsive seizures (petit mal and grand mal) have been reported, particularly in patients with EEG abnormalities or history of such disorders.
Abnormality of the cerebrospinal fluid proteins has also been reported.

Allergic Reactions Of a mild urticarial type of photosensitivity are seen. Avoid undue exposure to sun. More severe reactions, including exfoliative dermatitis, have been reported occasionally.

Endocrine Disorders Lactation and moderate breast engorgement may occur in females on large doses. If persistent, lower dosage or withdraw drug. False positive pregnancy tests have been reported, but are less likely to occur when a serum test is used. Amenorrhea and gynecomastia have also been reported. Hyperglycemia, hypoglycemia and glycosuria have been reported.

Autonomic Reactions Occasional dry mouth; nasal congestion; constipation; adynamic ileus; urinary retention; miosis and mydriasis.

Special Considerations in Long-Term Therapy Skin pigmentation and ocular changes have occurred in some patients taking substantial doses of phenothiazines, for prolonged periods.

Skin Pigmentation Rare instances of skin pigmentation have been observed in hospitalized mental patients, primarily females who have received the drug usually for three years or more in higher dosages. The pigmentary changes, restricted to exposed areas of the body, range from an almost imperceptible darkening of the skin to a slate gray color, sometimes with a violet hue. Histological examination reveals a pigment, chiefly in the dermis, which is probably a melanin-like complex. The pigmentation may fade following discontinuance of the drug.

Ocular Changes Ocular changes have occurred more frequently than skin pigmentation and have been observed both in pigmented and nonpigmented patients receiving phenothiazines, usually for two years or more. Eye changes are characterized by deposition of fine particulate matter in the lens and cornea. In more advanced cases, star-shaped opacities have also been observed in the anterior portion of the lens. The nature of the eye deposits has not yet been determined. A small number of patients with more severe ocular changes have had some visual impairment. In addition to these corneal and lenticular changes, epithelial keratopathy and pigmentary retinopathy have been reported. Reports suggest that the eye lesions may regress after withdrawal of the drug.
Since the occurrence of eye changes seems to be related to dosage levels and/or duration of therapy, it is suggested that long-term patients on moderate to high dosage levels have periodic ocular examinations.

Etiology The etiology of both of these reactions is not clear, but exposure to light, along with dosage/duration of therapy, appears to be the most significant factor. If either of these reactions is observed, the physician should weigh the benefits of continued therapy against the possible risks and, on the merits of the individual case, determine whether or not to continue present therapy, lower the dosage, or withdraw the drug.

Other Adverse Reactions Mild fever may occur after large I.M. doses. Hyperpyrexia has been reported. Increases in appetite and weight sometimes occur. Peripheral edema and a systemic lupus erythematosus-like syndrome have been reported.
Note: There have been occasional reports of sudden death in patients receiving phenothiazines. In some cases, the cause appeared to be asphyxia due to failure of the cough reflex. In others, the cause could not be determined. There is not sufficient evidence to establish a relationship between such deaths and the administration of phenothiazines.

DOSAGE AND ADMINISTRATION Initial and maintenance doses of MOBAN® (molindone hydrochloride) should be individualized, and the minimal effective dose should be employed. Elderly and debilitated patients should be started on lower dosage.

Dosage schedule, based on severity of symptomatology
1. Mild—5 mg three or four times a day; an increase to 15 mg three or four times a day may be required.
2. Moderate—10 mg three or four times a day; an increase to 25 mg three or four times a day may be required.
3. Severe—daily dosage as high as 225 mg may be required.

DRUG INTERACTIONS Potentiation of drugs administered concurrently with MOBAN® (molindone hydrochloride) has not been reported. Additionally, animal studies have not shown increased toxicity when MOBAN® is given concurrently with representative members of three classes of drugs (i.e., barbiturates, chloral hydrate and antiparkinson drugs).

MANAGEMENT OF OVERDOSAGE Symptomatic, supportive therapy should be the rule.
Gastric lavage is indicated for the reduction of absorption of MOBAN® (molindone hydrochloride) which is freely soluble in water.
Since the absorption of MOBAN® (molindone hydrochloride) by activated charcoal has not been determined, the use of this antidote must be considered of theoretical value.
Emesis in a comatose patient is contraindicated. Additionally, while the emetic effect of apomorphine is blocked by MOBAN® in animals, this blocking effect has not been determined in humans.
A significant increase in the rate of removal of unmetabolized MOBAN® from the body by forced diuresis, peritoneal or renal dialysis would **not** be expected. (Only 2% of a single ingested dose of MOBAN® is excreted unmetabolized in the urine.) However, poor response of the patient may justify use of these procedures. While the use of laxatives or enemas might be based on general principles, the amount of unmetabolized MOBAN® in feces is less than 1%.
Extrapyramidal symptoms have responded to the use of diphenhydramine (Benadryl*) and the synthetic anticholinergic antiparkinson agents, (i.e., Artane*, Cogentin*, Akineton*).

HOW SUPPLIED As tablets in bottles of 100 and 1000 with potencies and colors as follows:

5 mg orange	*Benadryl—Trademark, Parke Davis and Co.
10 mg lavender	*Artane—Trademark, Lederle Laboratories
25 mg light green	*Cogentin—Trademark, Merck Sharp & Dohme
	*Akineton—Trademark, Knoll Pharmaceutical Co.

Endo Laboratories, Inc.
Subsidiary of E.I. du Pont de Nemours & Co. (Inc.)
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DUPONT

MOBAN® IS AN ENDO REGISTERED U.S. TRADEMARK
U.S. PAT. 3,491,093

EN-5371 PRINTED IN U.S.A. APRIL 1975

Five Separate Campuses

Five **separate campuses** providing individually prescribed programs of care, education, treatment and training for children, adolescents and adults with learning disabilities, neurological impairment, mental retardation or emotional disturbance.

Advantage: the availability of **a large trained and experienced staff,** exchanging ideas and insights in a comprehensive program of supportive environment and individualized treatment.

Advantage: **geographically separated** to provide the proper residential milieu . . yet near enough to benefit from the combined training and experience of a wide range of staff members.

THE OAKS— intensive residential psychiatric treatment for emotionally disturbed children and adolescents to 16 years of age. Coeducational, Austin.

Brown Hall–90 ACRES–Residential psychiatric treatment and training for older children and adolescents with learning disabilities, neurological impairment, mental retardation and varying degrees of emotional disturbance. Brown Hall, young men; 90 Acres, young women. San Marcos.

Hillview and The Ranch—longer term care and treatment for those who must continue to live in a protected environment; prevocational training, Hillview, coeducational, San Marcos. Ranch, males only, Austin.

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THE BROWN SCHOOLS

THERE IS NOW A NEW DIMENSION IN THINKING ABOUT HUMAN BEINGS!

C. David Jones, M.D., a world recognized medical scientist, listed in the Dictionary of International Biography, teaches at the Chicago Medical School and maintains his own large practice utilizing hominological therapy with outstanding success. He has written a book called: HOMINOLOGY — PSYCHIATRY'S NEWEST FRONTIER.

For the first time *moral values* are clearly integrated into concepts of mental health, education, international affairs and physical disease. All of these concepts are meaningfully tied together in a manner that is easy and pleasant to read yet offers principles, ideas and guidelines that can be readily utilized and immediately applied.

Dr. Jones' book is truly revolutionary in its innovations making other concepts in the field of community mental health, psychotherapy and diagnosis obsolete. The concensus of those who have previewed it is that "no one in the field of mental health should be without it!"



C. David Jones, M.D. F.R.S.H.

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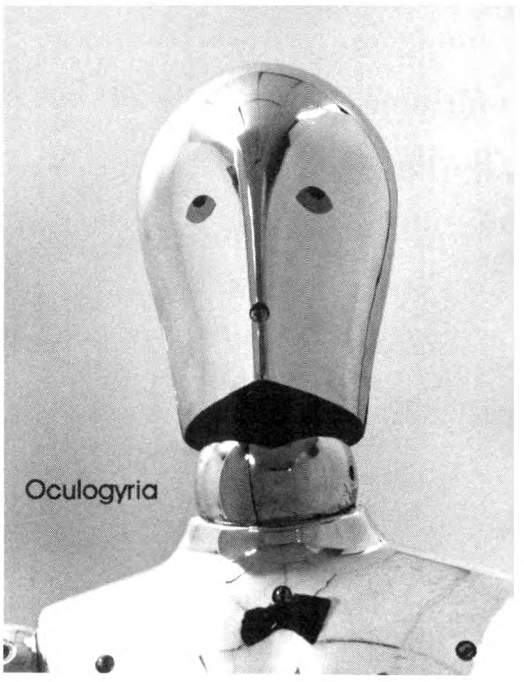
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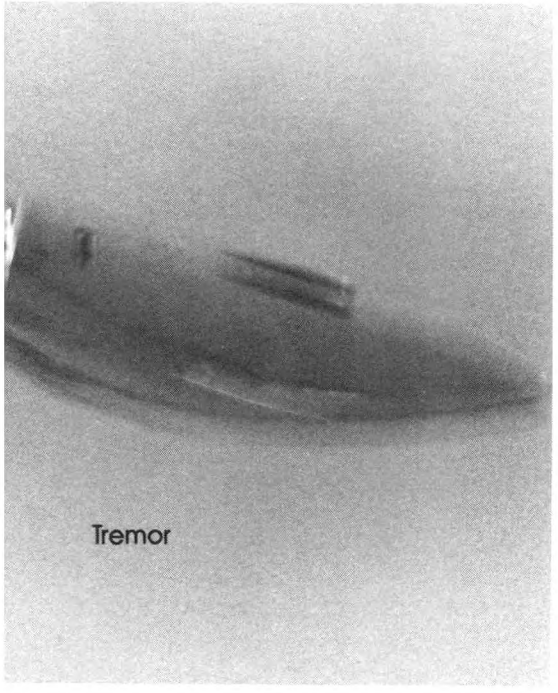
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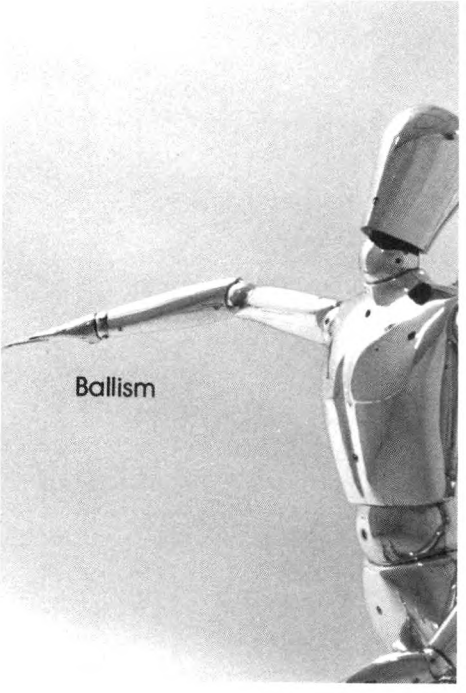
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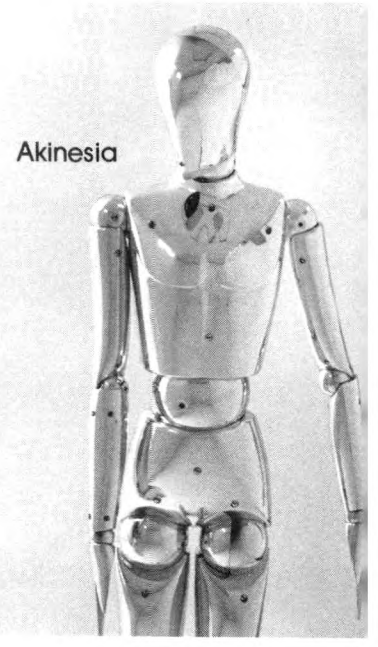
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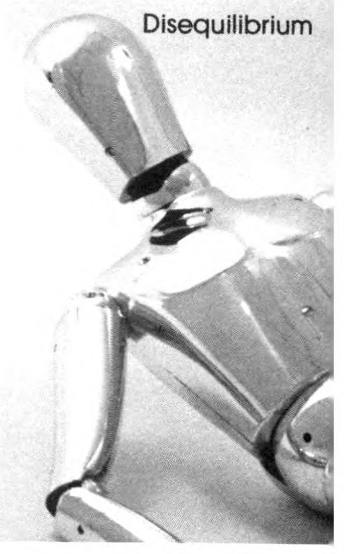

Thigh rubbing

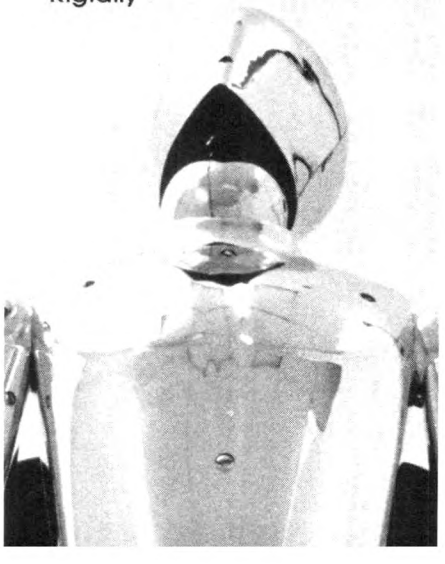

Oculogyria

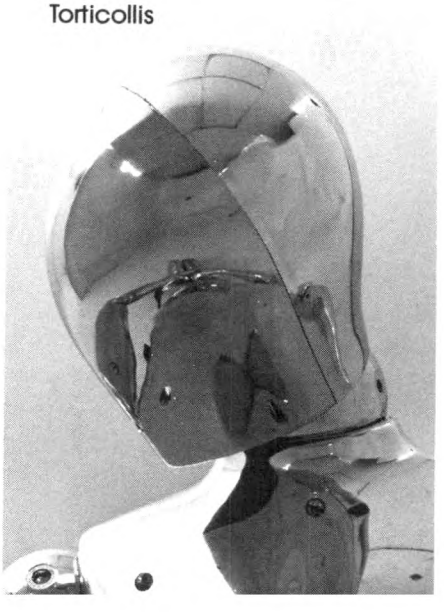

Tremor


Ballism

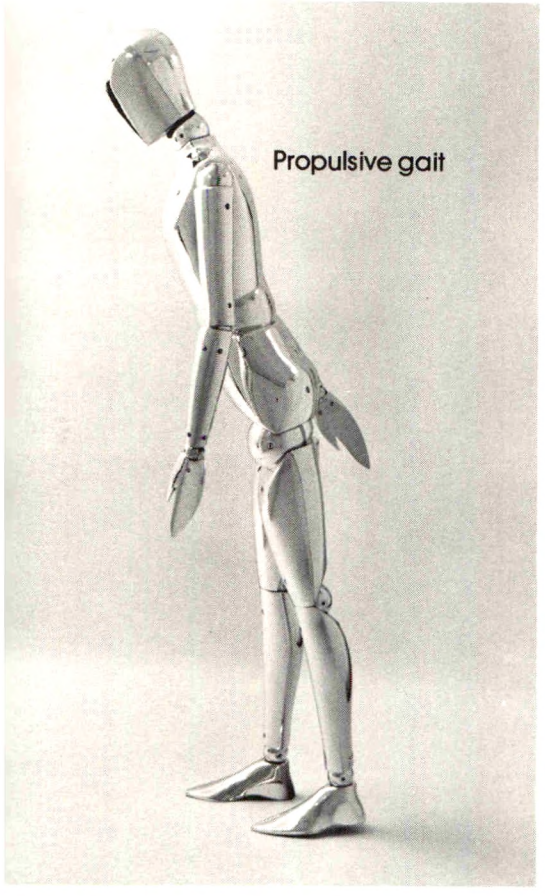

Akinesia

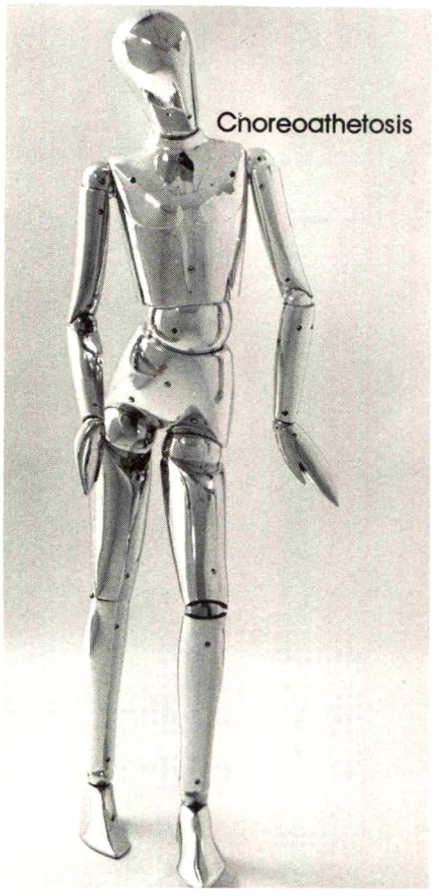

Disequilibrium


Rigidity


Torticollis

Humanizer





■ ARTANE® Trihexyphenidyl HCl. It can prevent or reverse the sometime dehumanizing extrapyramidal effects of the antipsychotic drugs. ■ But without the drug buildup potential of cumulative action anticholinergics. ■ And at lower cost.

Tablets:
2 mg and 5 mg

Elixir:
2 mg/5 cc with 0.08% methylparaben, 0.02% propylparaben and 5% Alcohol as preservatives.

SEQUELS®
Sustained Release Capsules: 5 mg

Tablets and Elixir: Indications: FDA has evaluated this drug as Effective as an adjunct in the therapy of the indications listed below under SEQUELS.

***INDICATIONS FOR ARTANE SEQUELS:**
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms of parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for the use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine and phenothiazines.

WARNING:
Patients to be treated should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated. Periodic gonioscopic evaluations in all patients to be treated with this or any related drug is advised.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilatation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache. Angle-closure glaucoma due to long-term treatment with this drug has been reported.

ARTANE®

TRIHEXYPHENIDYL HCl

TO REMOVE THE "CHEMICAL STRAITJACKET"

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Co. Pearl River, N.Y. 10965

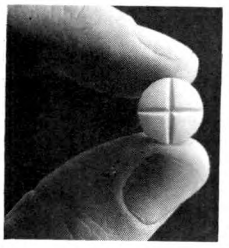
833-4

ANTABUSE: "Social security" for the alcoholic who wants to stop drinking...



The temptation is resisted, ANTABUSE (disulfiram) represents the security alcoholics need in any situation. They are better able to abstain from drinking because they know the consequences of taking "even one."

until psychiatric support can do the rest



Undoubtedly it will take considerable time for psychotherapy to help the chronic alcoholic. As a psychiatrist, you have undoubtedly selected the patients who are best motivated to stay with ANTABUSE while you attempt to deal with the underlying emotional problems. And, of course, you know the importance of reminding patients of the serious consequences of drinking while on ANTABUSE.

Once sober, and well into treatment, the alcoholic, at your discretion, can participate in a total treatment program which makes use of various supportive resources in the community. In the meantime, ANTABUSE can help the chronic alcoholic abstain from drinking.

BRIEF SUMMARY
(For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) in Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g. cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE (disulfiram) should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE (disulfiram), report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

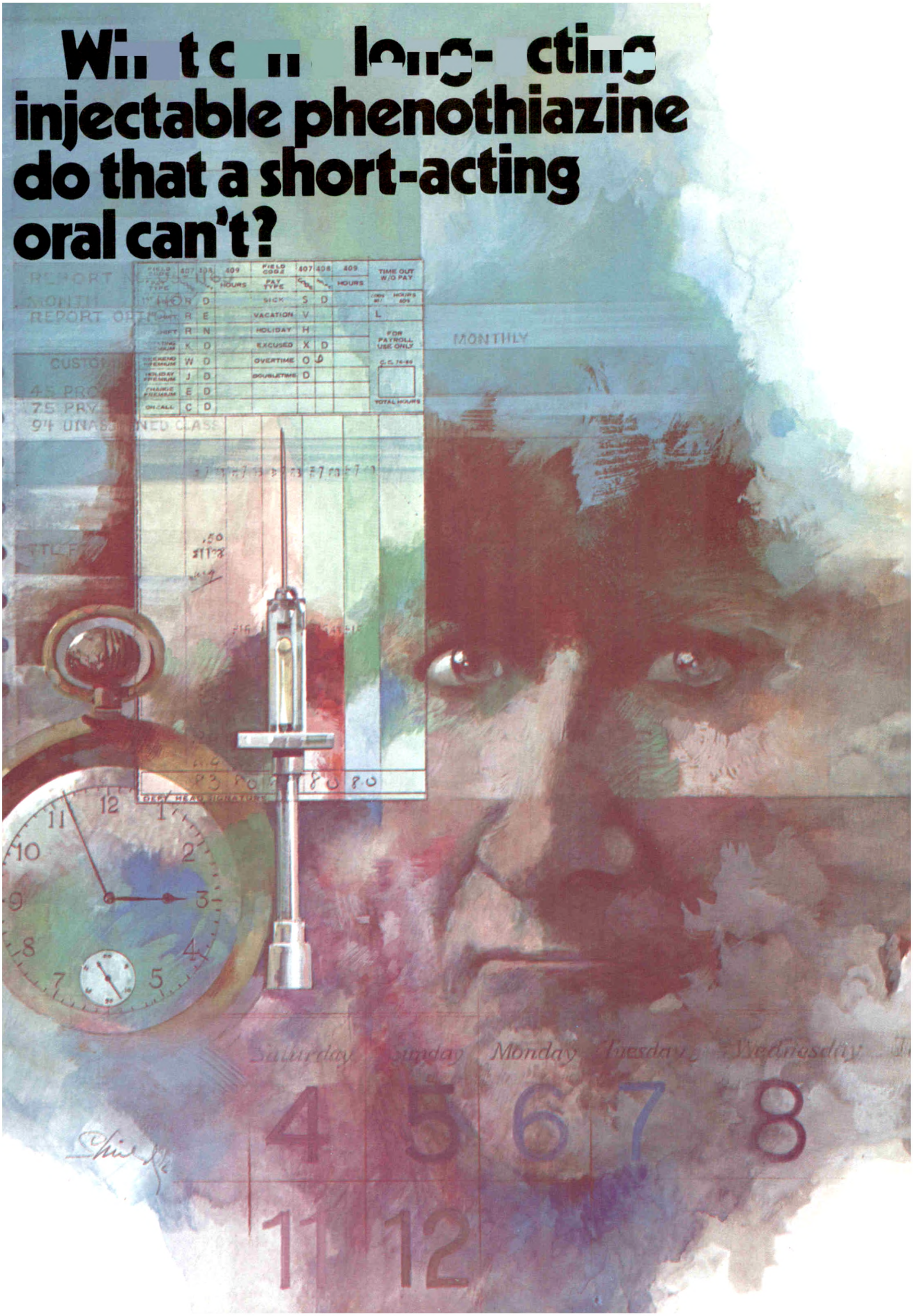
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7461

ANTABUSE®

BRAND OF DISULFIRAM

What can long-acting injectable phenothiazine do that a short-acting oral can't?



It can save time, it can save money, and it can even save people – by reducing readmissions.

Time Prolixin Decanoate (Fluphenazine Decanoate Injection), with duration of action that may last up to 4 weeks or longer in patients on maintenance therapy, can effect important savings in nursing time.

Approximate Staff Time Required to Medicate 18 Schizophrenic Patients*

a.m. ¾ hr. p.m. ¾ hr. p.m. ¾ hr.	1 injection every 28 days for most patients
= 2¼ hours nursing time	4 minutes required for each injection
¼ hrs. x 28 days = 63 hours of nursing time every 28 days	= 1 hr., 10 minutes nursing time in 28 days
NURSING TIME SAVED IN 28 DAYS	61 hours and 50 minutes or more than 7½ eight-hour working days

*Adapted from Platt R: Br J Social Psychiatry 2: 187-191, 1968.

Money Martin and Townend[1], who found from their study of Prolixin Decanoate that 15 of 39 patients could be maintained on 25 mg. every 4 weeks, also note that on this basis "a year's maintenance on chlorpromazine represents the order of 110 grams of phenothiazine as opposed to 0.33 gram of fluphenazine." Translating this into dollars shows the following potential hospital savings on the basis of patient population:

Agent and amount/year	Form	Cost/patient/year	Cost/500 patients/year
Chlorpromazine (SKF brand) 110 grams	8 oz. concentrate 100 mg./ml.†	$48.75*	$24,375
Prolixin Decanoate .33 grams	5 ml. vials 25 mg./ml.	23.17**	11,585
SAVINGS		$25.58 patient, year	$12,790 500 pts/yr.

* Calculated from prices published in 1975 Red Book.
** Calculated from Squibb 1975 price catalogue.
† With tablets, the annual cost is even greater.

People The controlled drug delivery system of Prolixin Decanoate helps get schizophrenic patients out of the hospital and helps them stay out. It promotes continuity of therapy—reducing outpatient drug defaulting from approximately 50% with oral medications according to one report[2] to about 16% according to another report[3].

It reduces the number and length of rehospitalizations. In one study of 103 patients maintained on injections of long-acting fluphenazines, total hospital readmissions for a year were cut from 191 to 50 and inpatient time from 8,713 days to 1,335 days[4].

It facilitates return to a productive life. A 12-month followup of 103 discharged patients revealed 77% in full-time employment or household duties and only 23% unemployed[4].

PROLIXIN DECANOATE®

(Fluphenazine Decanoate Injection)

may control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

SQUIBB® 'The Priceless Ingredient of every product is the honor and integrity of its maker.'™

References:
1. Martin ICA and Townend RA: Brit J Psychiat 124: 173-6, 1974.
2. Goldberg HL, DiMascio A, Chaudhary B: Psychosomatics 11: 173-177, 1970.
3. Medical World News, February 11, 1972, p. 58H.
4. Denham J and Adamson L: Can Psychiat Assoc J 18: 235-7, 1973.

For product brief summary see following page.

H425-001R

PROLIXIN DECANOATE®

(Fluphenazine Decanoate Injection)

may control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

rolixin Decanoate (Fluphenazine Decanoate Injection) provides 5 mg. fluphenazine decanoate per ml. in a sesame oil vehicle with .2% (w/v) benzyl alcohol as a preservative.

ONTRAINDICATIONS: In presence of suspected or established subortical brain damage. In patients who have a blood dyscrasia, liver amage or renal insufficiency, or who are receiving large doses of ypnotics, or who are comatose or severely depressed. In patients who ave shown hypersensitivity to fluphenazine; cross-sensitivity to phe-othiazine derivatives may occur.

Not intended for use in children under 12.

/ARNINGS: Mental and physical abilities required for driving a car r operating heavy machinery may be impaired by use of this drug. hysicians should be alert to the possibility that severe adverse re-ctions may occur which require immediate medical attention. Potentia-on of effects of alcohol may occur. Safety and efficacy in children ave not been established because of inadequate experience in use n children.

Usage in Pregnancy: Safety for use during pregnancy has not been stablished; weigh possible hazards against potential benefits if ad-ninistering this drug to pregnant patients.

'RECAUTIONS: Caution must be exercised if another phenothiazine ompound caused cholestatic jaundice, dermatoses or other allergic eactions because of the possibility of cross-sensitivity. When psychotic atients on large doses of a phenothiazine drug are to undergo surgery, ypotensive phenomena should be watched for; less anesthetics or entral nervous system depressants may be required. Because of added nticholinergic effects, fluphenazine may potentiate the effects of tropine.

Use fluphenazine decanoate cautiously in patients exposed to ex-reme heat or phosphorus insecticides; in patients with a history of :onvulsive disorders since grand mal convulsions have occurred; and n patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in nind that with prolonged therapy there is the possibility of liver damage, oigmentary retinopathy, lenticular and corneal deposits, and develop-nent of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should oe monitored; if BUN becomes abnormal, treatment should be dis-continued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkin-sonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will de-oend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually oe controlled by administration of antiparkinsonian drugs such as benz-tropine mesylate or intravenous Caffeine and Sodium Benzoate Injec-tion U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, per-sistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involun-tary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams; reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recom-mended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a prob-lem, patients with pheochromocytoma, cerebral vascular or renal in-sufficiency or severe cardiac reserve deficiency such as mitral insuf-ficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dos-age will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal con-gestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, ab-normal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photo-sensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocy-tosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If sore-ness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particu-larly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accom-panied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be pre-disposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 ml. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 ml. vials.

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PSYCHIATRISTS

Board eligible and board certified to fashion positions within innovative programs. New medical school affiliation with medical students and residents training within clinical programs. Research and formal teaching opportunities are available. Positions in the Triage-Crisis Intervention, Acute Psychiatry and Intermediate Psychiatry, Out-patient Psychiatry Programs. Salaries from $29,846 to $36,000 based upon qualifications. No discrimination in employment. Apply to Chief of Psychiatry, VA Hospital, Downey, Illinois 60064.

The Prince George Regional Hospital

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The Prince George Regional Hospital currently expanded to a 370 bed fully accredited active treatment Regional referral hospital, located in Central B.C. The Hospital is situated in the City of Prince George that has a population of 65,000 and serves an area of 150,000. There are 70 practicing physicians, 36 of which are Specialists. Prince George is one of the fastest growing Communities in the Province and offers excellent educational and recreational facilities with easy access to Vancouver and other parts of Canada.

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Needed at 951 bed modern NP Center; salary up to $36,000 per annum depending on qualifications; excellent fringe benefits; non-discrimination in employment; full and unrestricted license required; may be from any state; travel and transportation costs may be supported. Contact Chief of Staff, VA Hospital, Leech Farm Road, Pittsburgh, PA 15206, or telephone 412-363-4900, Extension 223 or 244.

FACULTY POSITION IN PSYCHIATRY AVAILABLE

Texas A&M University is currently developing a new Program in Medical Education; the two-year preclinical course of instruction will be presented primarily on the TAMU campus; the clinical curriculum, occupying the 3rd and 4th years, will utilize the faculty and facilities of the Baylor College of Medicine and its affiliated hospitals in Houston as well as the Veterans Administration Center and the Scott & White Clinic and Hospital in Temple, Texas. A program director for psychiatry and behavioral science is needed. Teaching in the first two years of medical school will be a major responsibility. Qualified persons are invited to make application. Letters of application should include a resume of pertinent prior experience and training and may be directed to James A. Knight, M.D., Dean of Medicine, Texas A&M University, College Station, Texas 77843.

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Exploring the Nondrug Parameters of Tranquilizer Effectiveness No. 1

How individual patient variables influence

It is now well established that certain nondrug factors can affect response to antianxiety medication. Thus, even with agents of proven efficacy, such as Librium (chlordiazepoxide HCl), different patients may exhibit varying degrees of symptomatic relief from excessive anxiety and tension.

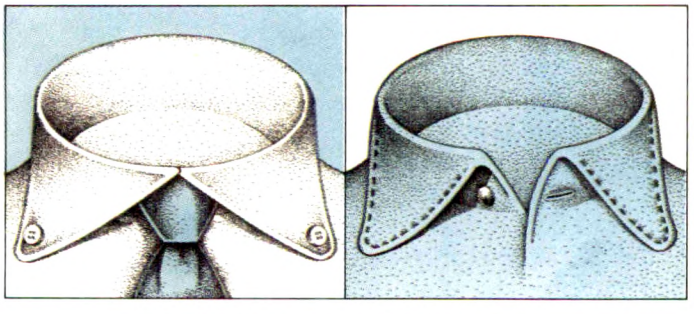
Apart from the effect of the physician's personality and prescribing attitudes on patient response,[1] there are certain significant patient variables, *e.g.*, personality type, severity and duration of anxiety, socioeconomic status, attitude toward medication and insight into the nature of the condition under treatment.[2-4] Thus, some clinical experience suggests that physically active extroverts, for whom abatement of anxiety may decrease the will to achieve or take action, may respond negatively – resulting in exacerbation of anxiety.[2] On the other hand, more passively anxious individuals with intellectual and esthetic inclinations have been shown to benefit from antianxiety medications.

When medication is indicated in the latter group, many psychiatrists place a high value on the benzodiazepines – of which Librium (chlordiazepoxide HCl) was the first in clinical use – for their antianxiet effectiveness, broad usefulness and wide margin of safety.[2,3]

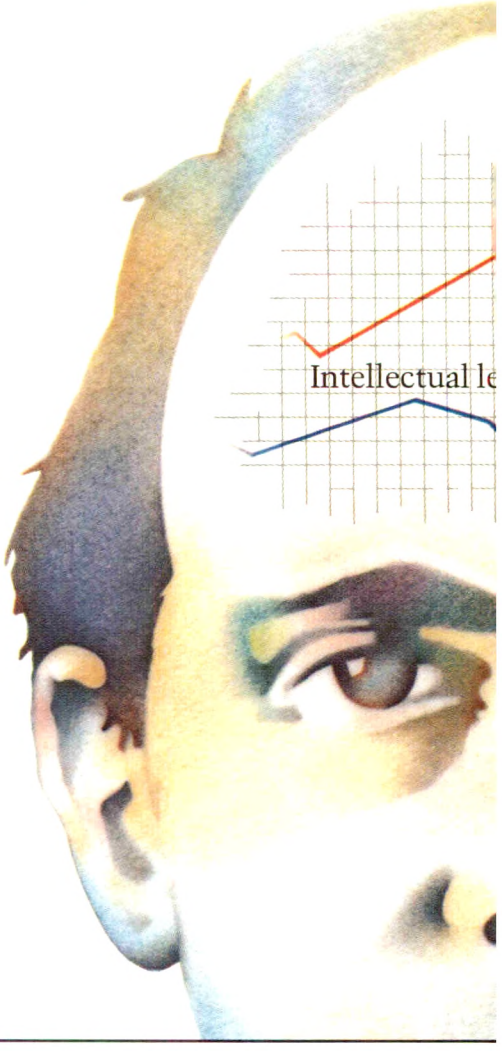
1. Rickels K, Lipman RS, Park LC, Covi L, Uhlenhuth EH, Mock JE: *Psychopharmacologia 20*:128-152, 1971
2. Hollister LE: *Ann Intern Med* 79:88-98, July 1973
3. Greenblatt DJ, Shader RI: *Ibid.*, 77: 91-100, July 1972
4. Rickels K, Downing RW, Howard K: *Clin Pharmacol Ther 12*:263-273, Mar-Apr 1971



Attitude to medication



Socioeconomic status



The effectiveness of antianxiety therapy

Demonstrated predictors of favorable response to Librium (chlordiazepoxide HCl)

In a double-blind, controlled study[4] of psychoneurotic patients with moderately severe anxiety, 111 patients were treated with Librium in a daily dosage of 30 to 40 mg, and 201 patients received a placebo. Outcome criteria included a global improvement measure after 2 and 4 weeks and the 4-week change score of a 10-item physician questionnaire.

Statistical analysis revealed that the greatest drug-placebo difference in relieving anxiety occurred among patients who were more severely ill, those in a higher socioeconomic class and those whose illness had persisted for at least six months. The more educated patient with high verbal ability, greater insight and an accepting attitude toward combined psychotherapy and drug therapy responded *significantly better* to Librium than to the placebo. On the other hand, patients of lower socioeconomic status, with less insight and greater readiness to accept medication alone as sufficient therapy, tend to show a moderately favorable response to both drug *and* placebo.

For proven effectiveness against excessive, obstructive anxiety

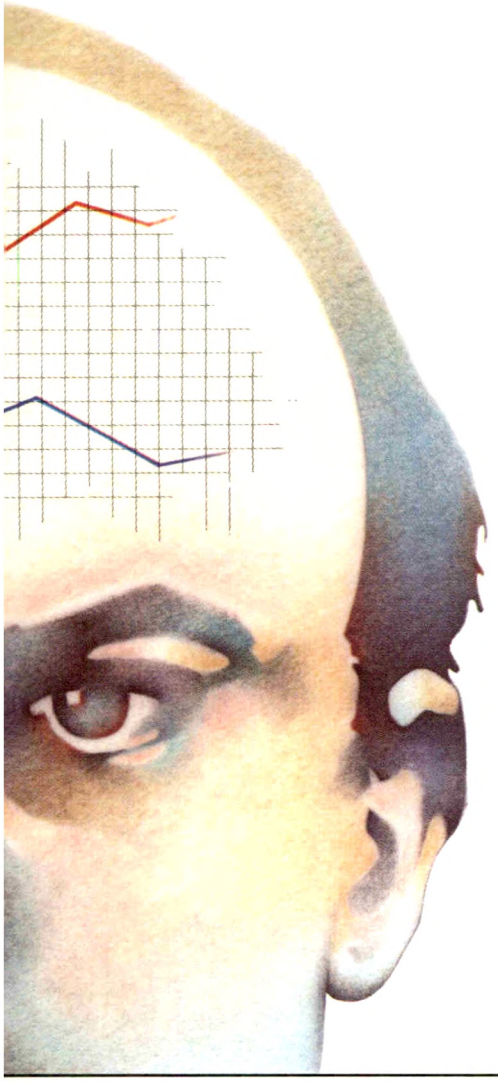
adjunctive

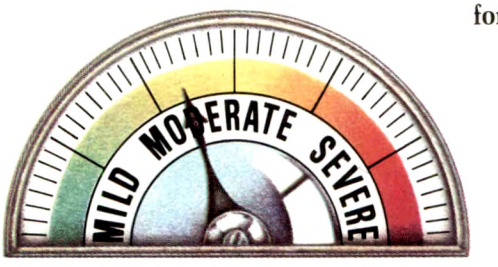
ROCHE **Librium®**

(chlordiazepoxide HCl)

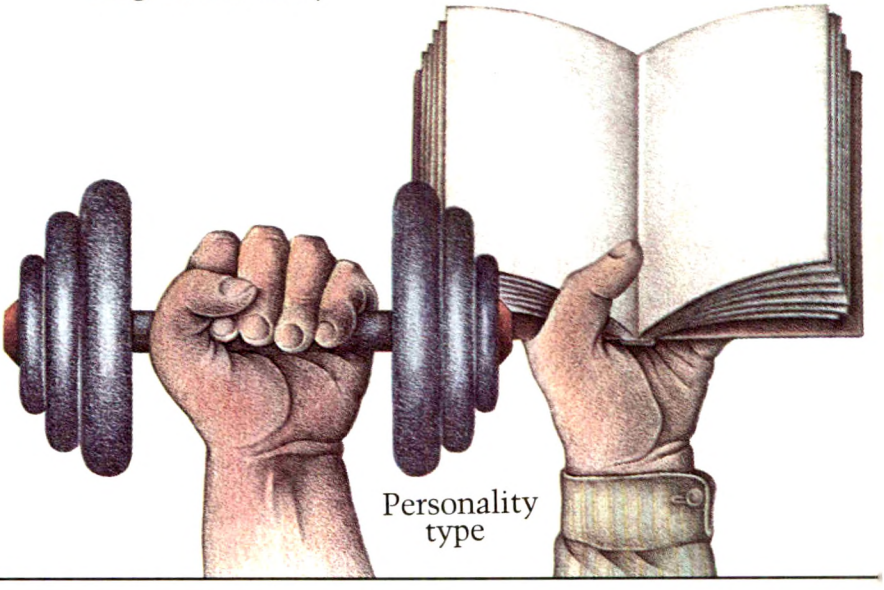
10 mg, 25 mg capsules

Please see following page for summary of product information.





Degree of anxiety



Personality type

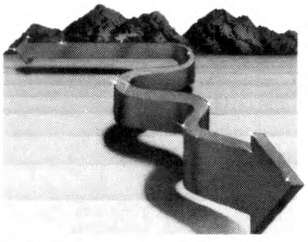
Effective adjunct in psychotherapy

Librium® (chlordiazepoxide HCl)

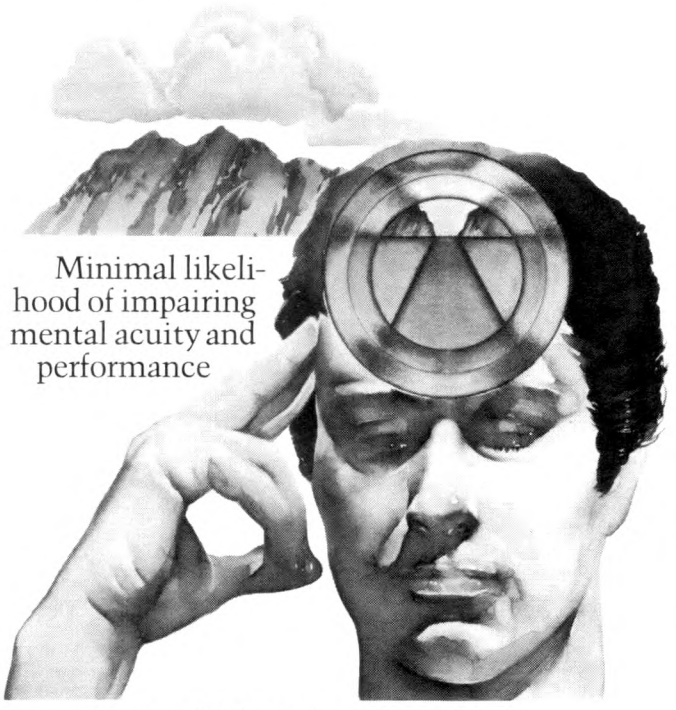
10 mg, 25 mg capsules/up to 100 mg daily in severe anxiety

While drowsiness, ataxia and confusion are the most frequently occurring side effects, physicians should be aware of the possibility of more serious reactions. Before prescribing, please consult complete product information, a summary of which appears below.

When anxiety has been reduced to useful, appropriate levels, Librium should be discontinued.



Wide margin of safety



Minimal likelihood of impairing mental acuity and performance

Dependable antianxiety action

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido – all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral – Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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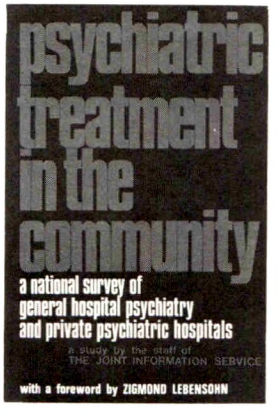
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Consider the advantages of starting her on HALDOL® (haloperidol)

Acts promptly to control hostility and suspiciousness

Several clinicians have cited the special value of HALDOL haloperidol in controlling hostility, suspiciousness, ideas of persecution and other delusions associated with psychoses.[1-6] Symptom control is achieved rapidly, with many patients showing distinct improvement in a few days to a week[1,6]—frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[7,8]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL haloperidol is rare. In fact, this drug has been reported to increase activity in some underactive patients, while in hyperactive patients it usually reduces activity to a normal level without somnolence. HALDOL haloperidol has been found to "normalize" behavior and produce a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[4]

Reduces likelihood of certain adverse reactions

HALDOL haloperidol, a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. The most commonly noted side effects of HALDOL haloperidol—extrapyramidal reactions—are usually dose-related and readily controlled with antiparkinson drugs.

Transient hypotension occurs rarely; severe orthostatic hypotension has not been reported. HALDOL haloperidol is also unlikely to cause hepatic damage, serious hematologic reactions, photosensitivity reactions and skin rashes. Ocular damage and pigmentation changes have not been reported.

References: 1. Towler, M.L., and Wick, P.H.: Int. J. Neuropsychiat. 3: Suppl. 1,62 (Aug.) 1967. 2. Crane, G.E.: Int. J. Neuropsychiat. 3: Suppl. 1,111 (Aug.) 1967. 3. Ban, T.A., and Lehmann, H.E.: Int. J. Neuropsychiat. 3: Suppl. 1,79 (Aug.) 1967. 4. Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965. 5. Yun, B.S., et al.: Mich. Med. 67:1349 (Nov.) 1968. 6. Rubin, R.: Alabama J. Med. Sci. 8:414 (Oct.) 1971. 7. Reschke, R.W.: Dis. Nerv. Syst. 35:112 (Mar.) 1974. 8. Palestine, M.L., and Alatorre, E.: Quart. J. Stud. Alcohol 34:185 (Mar.) 1973.

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tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

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highly specific control of disordered and disruptive behavior

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Indications: HALDOL haloperidol is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome.

Contraindications: HALDOL haloperidol is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL haloperidol in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of haloperidol orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL haloperidol, decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL haloperidol may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL haloperidol should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL haloperidol may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant antiparkinson medication is required, it may have to be continued after HALDOL haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson agents, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of antiparkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long-term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed. 9/74

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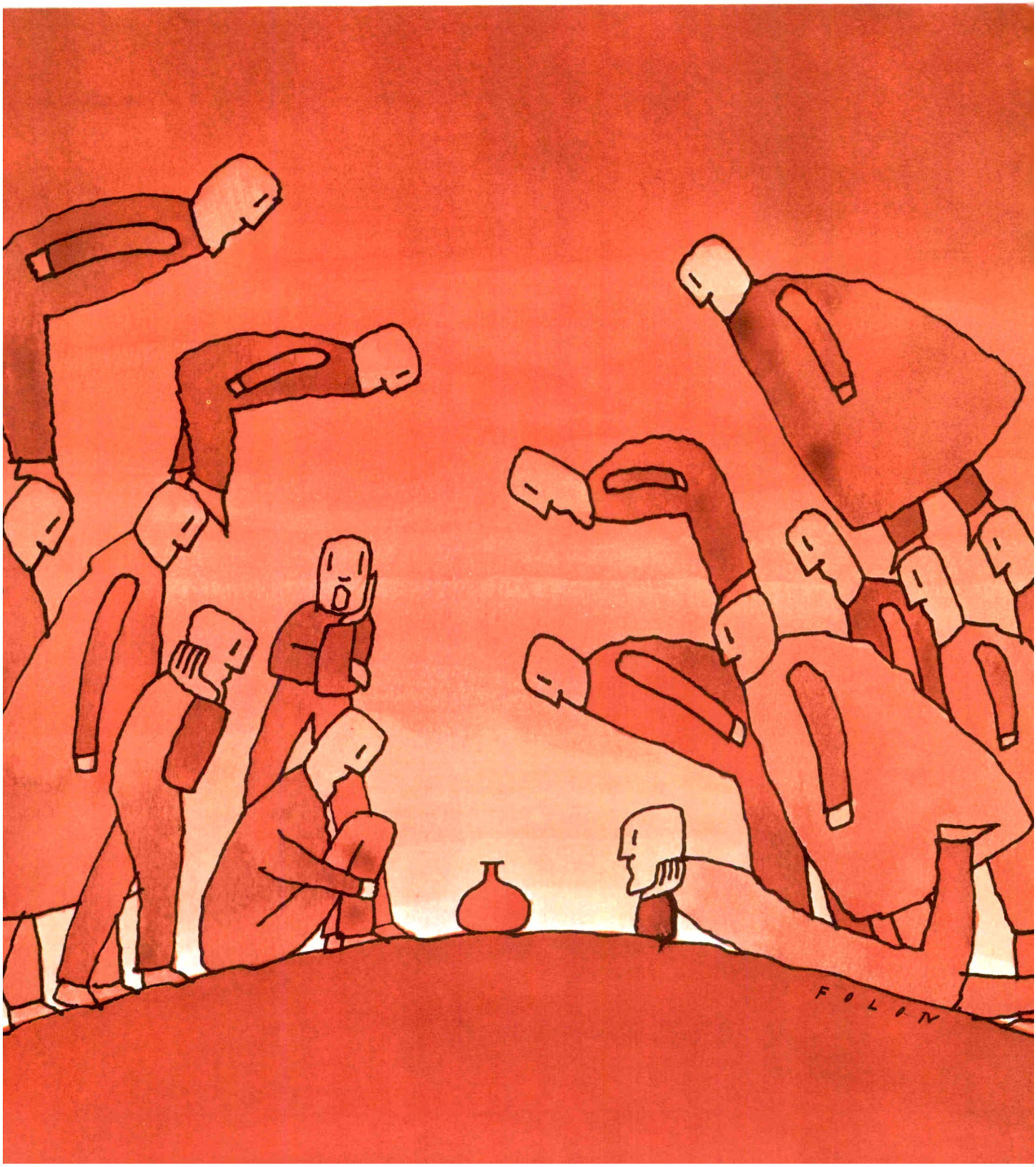
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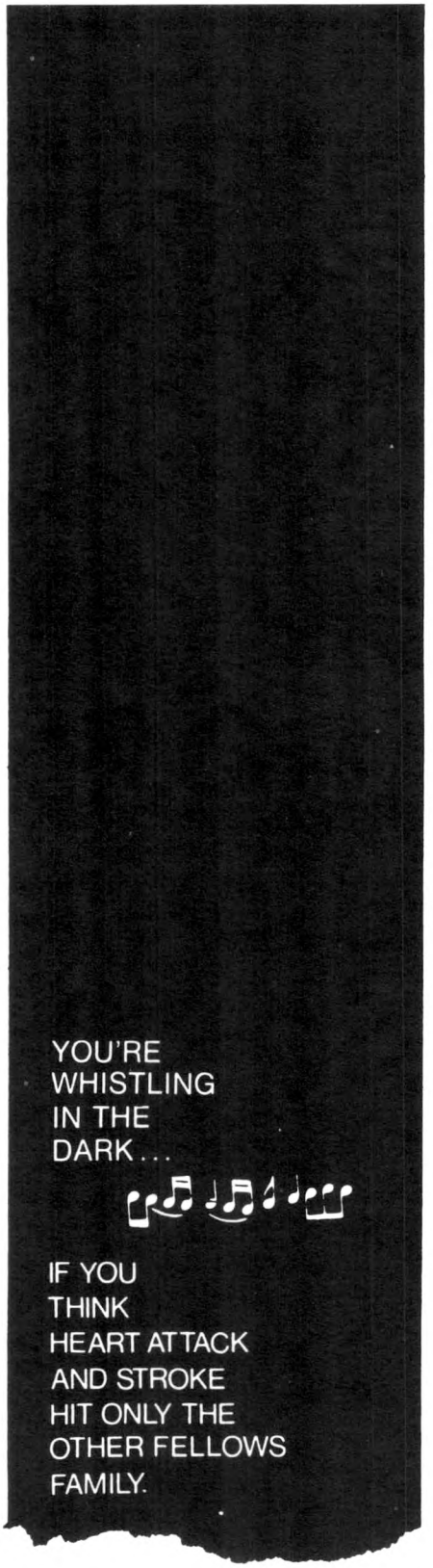
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Contraindications: The only known contraindication is sensitivity to Akineton hydrochloride.

Warnings: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients.

Precautions: Caution should be observed in patients with manifest glaucoma, though no prohibitive rise in intraocular pressure has been noted following either oral or parenteral administration. Patients with prostatism or cardiac arrhythmia should be given this drug with caution. Occasionally, drowsiness may occur.

Adverse reactions: Adverse reactions encountered are primarily dry mouth and blurred vision. These side effects are usually slight and can be overcome by judicious reduction of dosage. If gastric irritation occurs, it can be avoided by administering during or after meals.

Dosage and Administration: Doses required to achieve therapeutic goal are variable and must be individually and gradually adjusted.

Parkinson's disease: 1 tablet, 2 mg. three or four times daily.

Drug-induced extrapyramidal disorders: 1 tablet, 2 mg. one to three times daily.

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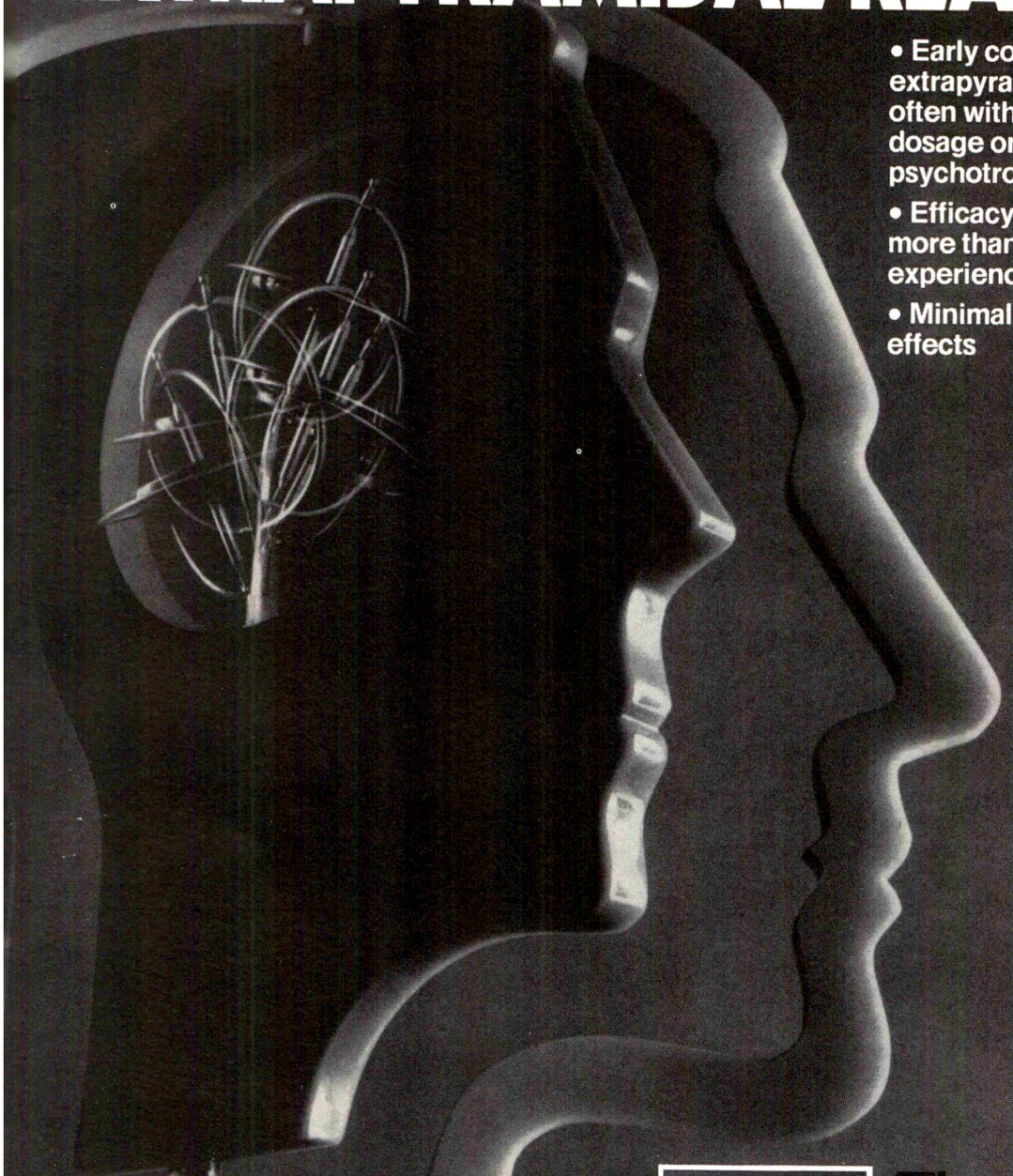
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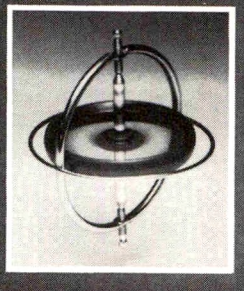
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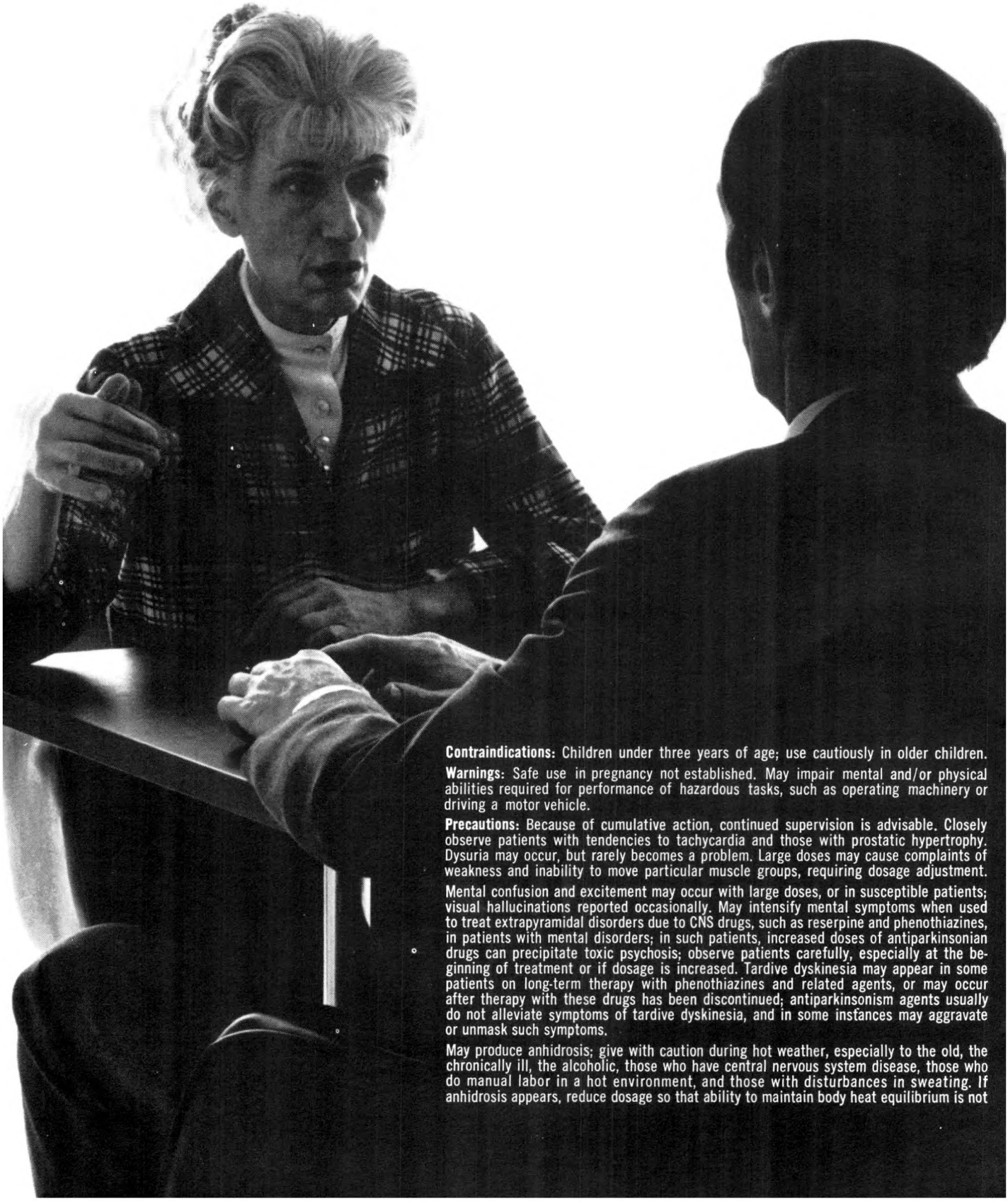


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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

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helps alleviate most phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; Injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

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Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to COGENTIN.

For more detailed information, see full prescribing information.

May be the start of a better life for the epileptic

About nine out of ten epileptics suffer their first seizure in childhood.[1] Certain physical and psychic postseizure evidence—a badly bitten tongue, broken or dropped objects, amnesia, exhaustion—may suggest grand mal. Once the diagnosis of epilepsy has been established, *MYSOLINE (primidone) may mean the start of a seizure-free life.*

Early therapy for control of grand mal, focal and psychomotor epilepsy. Used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. Based on years of clinical success, MYSOLINE has earned the reputation of being an *excellent* drug for control of grand mal epilepsy.[2-4] But its usefulness is not confined to this type alone: MYSOLINE has proved to be valuable for control of psychomotor[2,3] and focal epilepsy[5] as well.

Improves response to concomitant therapy. When other anticonvulsants prove to be inadequate, adding MYSOLINE to the regimen can improve seizure control in grand mal and psy



chomotor epilepsy. A double-blind comparative study[6] shows that the combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.

Effective changeover therapy. Unsatisfactory performance or important side effects may force discontinuation of the patient's existing anticonvulsant therapy. For more effective control, MYSOLINE may be added to the patient's present regimen, then gradually substituted for the original medication. The changeover to MYSOLINE is frequently warranted when grand mal is refractory to phenobarbital, with or without diphenylhydantoin.[7]

Mysoline®
(primidone)

See last page of advertisement for prescribing information.



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Mysoline® (primidone)
May be the start of a better life for the epileptic

initial and maintenance therapy for grand mal, psychomotor and focal epilepsy

BRIEF-SUMMARY

(For full prescribing information, see package circular.)

MYSOLINE® Brand of **PRIMIDONE**
Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used *in combination* with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, *e.g.*, genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K_1 therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone) and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average acult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	*2nd Week* 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	*4th Week* 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE (primidone) should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE *Tablets*—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE *Suspension*—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluidounces.

References: 1. Livingston, S., and Pruce, I.: Pediatr. Ann. 2:10 (Aug.) 1973. 2. Livingston, S., and Pruce, I. M.: Drug Therapy for Epilepsy, Springfield, Ill., Charles C Thomas, 1966, p. 23. 3. Scholl, M. L., in Conn, H. F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. 37:49 (Jan.) 1970. 5. Forster, F. M.: Med. Clin. North Am. 47:1579 (Nov.) 1970. 6. White, P. T.: Wis. Med. J. 68:178 (Apr.) 1969. 7. Millichap, J. G.: Drug Ther. 1:15 (Oct.) 1971.

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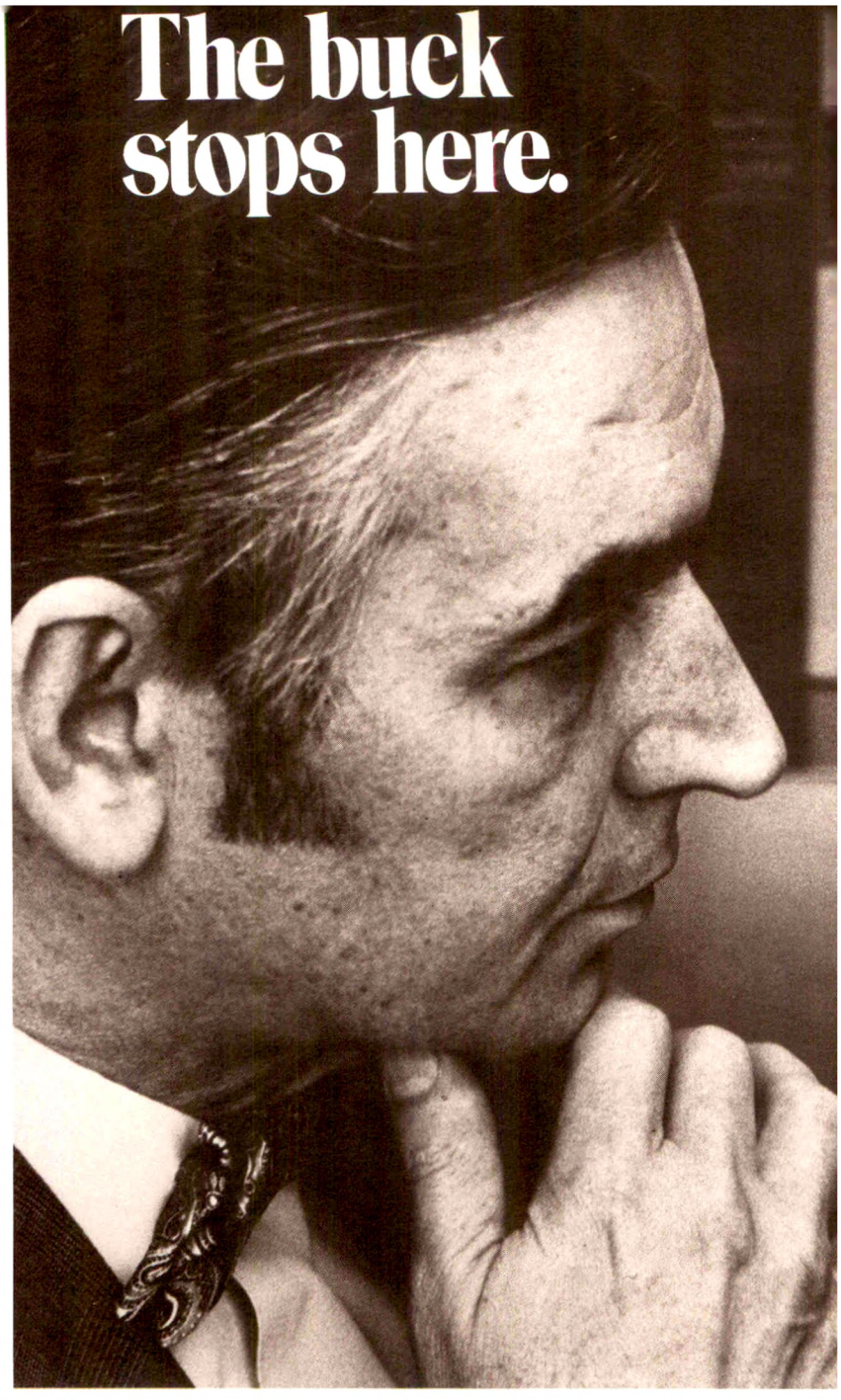
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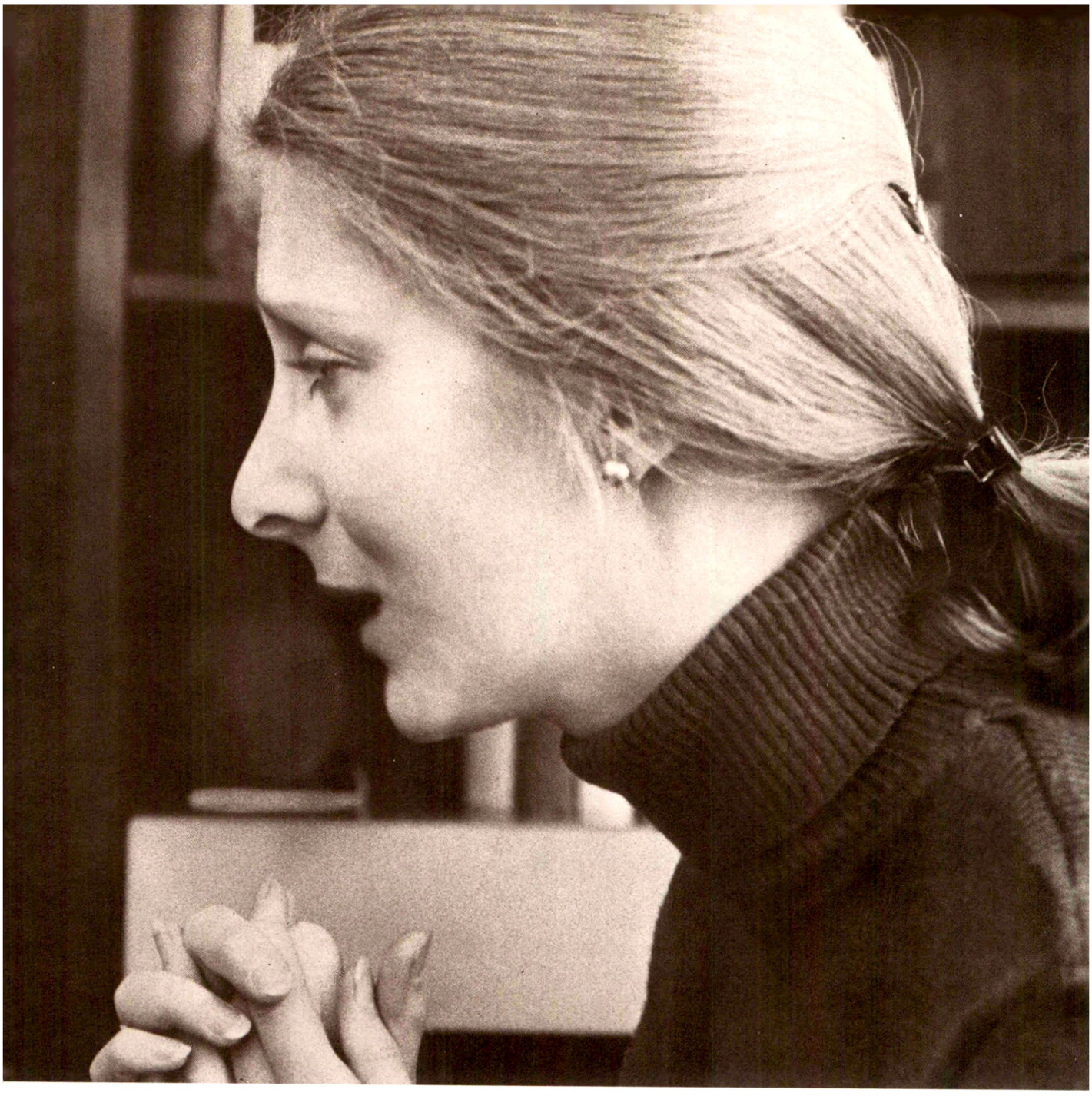
Indication: For relief of mental depression. **Contraindications:** Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane (desipramine HCl) in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine. **Dosage:** All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink), bottles of 100 and 1000. Also, 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.



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1. Marshall, M.H.: Psychopharmacology of Depression: Perspectives in Research, Psychosomatics 12:49, 1971.
2. Barringer, T.J.: Clinical Trial of Desipramine in the Treatment of Depression, Am. J. Psychiatry 121:1117, 1965.

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IBD Case History #1

1971 ...a difficult child, a distraught mother Medical diagnosis: MBD



Robert Boynton,* second of five children, born October 7, 1963. Normal pregnancy and delivery.[1]

From the age of 3, Robert's mother found him "hard to handle," "wilder" than his brothers and sisters.[1]

At age 6, after an "extremely difficult" experience in kindergarten, Robert was referred to a pediatric neurologist. The examination and later psychological testing revealed a host of the neurologic "soft signs," plus an abnormal EEG.[1]

The diagnosis: average intelligence, but multiple signs of an underlying organic dysfunction.[1]

At age 7, Robert was placed in a special first-grade class called an "extended readiness program."[1]

Later that year, her child's continued problems at school and at home made Robert's mother "increasingly desperate" for help.

An MBD child on the road to maturity..

1974 ...a regular fourth-grader, accepted at home

In the opinion of the physician, methylphenidate talin) was called for to help the child over the obsta- s of hyperactivity. So he initiated a trial of the drug, ich was then implemented on school days only.[1]

The improvement in classroom perform- ce and behavior was "prompt and dra- tic." Robert's teacher could "scarcely be- e" that he was the same child.[1]

For the past 4 years (as of April 1974), bert has been maintained on 15 mg thylphenidate daily during school iods. During the summer he attends y camp and is not on medication. He n a regular fourth-grade class, and navioral problems at home have sened. Robert's parents now find nuch easier to accept their son.[1]

ote: In this presentation, clini- material has been used factu- y with the permission of the physi- n. However, identities have been con- aled and names changed.



How other children with MBD can benefit m methylphenidate therapy

Of course, medication is not indicated for all 3D children; nor will all such children respond drug therapy.

However, when pharmacotherapy is clearly licated, the use of a widely successful drug such Ritalin (methylphenidate) may prove to be a significant element in many nplete remedial programs.

Over a decade of controlled studies has underlined the beneficial effects of alin in producing improved behavior ratings,[2,3] better motor coordination,[2,4] d cognition and learning.[2,4] Indeed, it is currently the drug of choice in many 3D situations.[5]

And side effects with Ritalin have occurred less frequently than with other mulant drugs.[4,6,7]

Dosage should be periodically interrupted in the presence of improved motor ordination and behavior. These interruptions often reveal that the child's havior shows some "stabilization" even without chemotherapy, permitting a duction in dosage and gradual elimination of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral orders not associated with medical diagnosis of MBD.



brief prescribing information, please see following page.

Ritalin® (methylphenidate)

an help when medication is indicated

CIBA

Ritalin®
(methylphenidate)
Only when medication is indicated



Ritalin®hydrochloride Ⓒ
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.

Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.

In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
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References:

1. Files of Medical Research Department, CIBA Pharmaceutical Company, Summit, New Jersey.
2. Knights RM, Hinton GG: *J Nerv Ment Dis* **148**:643-653, 1969.
3. Comly HH: *J Learning Disabil* **4**:484-490, 1971.
4. Conners CK: *J Learning Disabil* **4**:476-483, 1971.
5. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.
6. Paine RS: *Pediatr Clin North Am* **15**:779-800, 1968.
7. Conners CK: *Pediatrics* **49**:702-708, 1972.

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Effectiveness across the spectrum of most common forms of insomnia

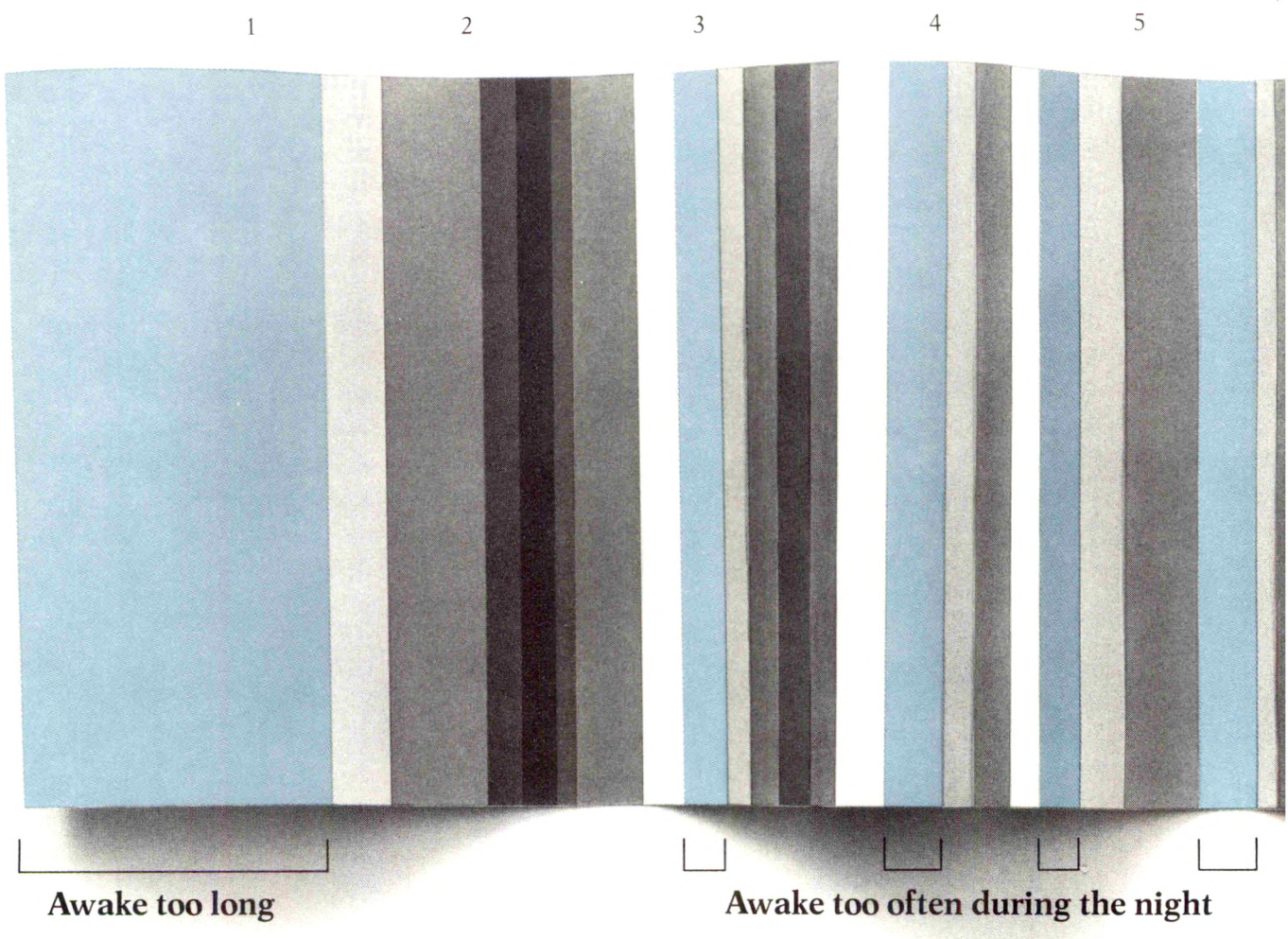
Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



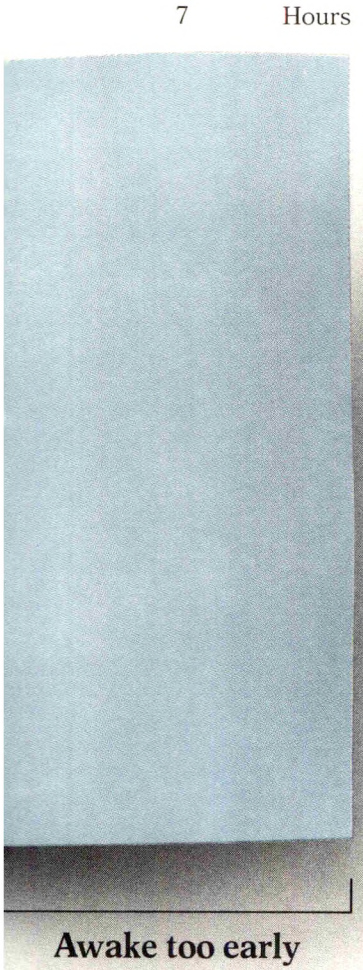
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia





Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

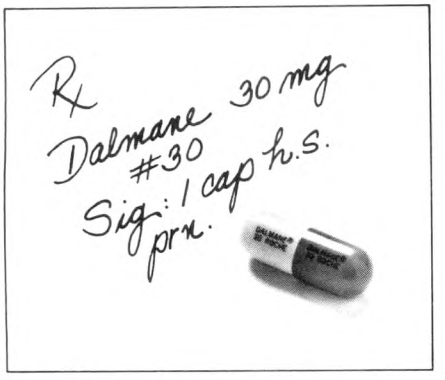
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl)



- □ induces sleep within 17 minutes, on average
- □ reduces nighttime awakenings
- □ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

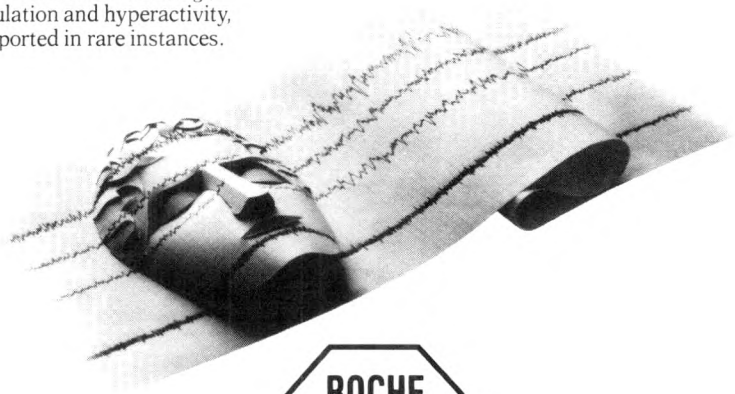
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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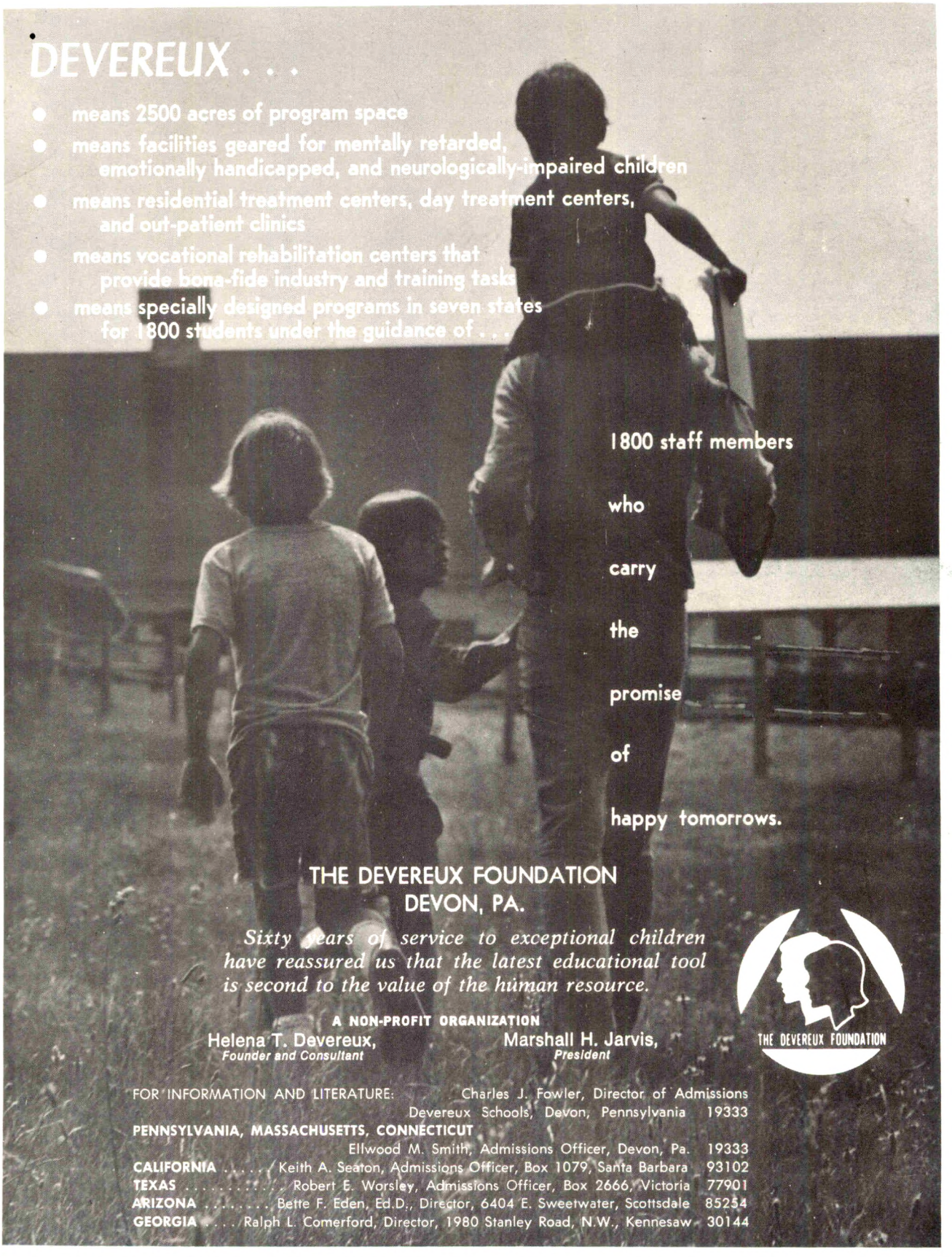
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Vol. 132, No. 6 June 1975

THE AMERICAN JOURNAL OF PSYCHIATRY

In this issue

An Overview of Marital Therapy
By Ellen M. Berman and Harold I. Lief

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Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, Tofranil, brand of imipramine hydrochloride, may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g., paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Avoid the use of preparations, such as decongestants and local anesthetics, which contain any sympathomimetic amine (e.g., adrenalin, noradrenalin), since it has been reported that tricyclic antidepressants can potentiate the effects of catecholamines.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. Dosage should be initiated with Tofranil, brand of imipramine hydrochloride, at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission.

Once-a-day maintenance dosage can be provided with Tofranil-PM, brand of imipramine pamoate, capsules if this dosage has been established as explained above. This dose may be given at bedtime. For the occasional patient who manifests stimulation and insomnia with this dosage regimen, the capsules may be given in the morning.

Parenteral administration should be used only for starting therapy in patients unable or unwilling to use oral medication. The oral form should supplant the injectable as soon as possible.

How Supplied: Tofranil, brand of imipramine hydrochloride: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg.; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

Tofranil-PM, brand of imipramine pamoate: Capsules of 75, 100, 125 and 150 mg. (Each capsule contains imipramine pamoate equivalent to 75, 100, 125 or 150 mg. of imipramine hydrochloride.) (B) 98-146-850-P (2/74

For complete details, including dosage and administration, please refer to the full prescribing information.

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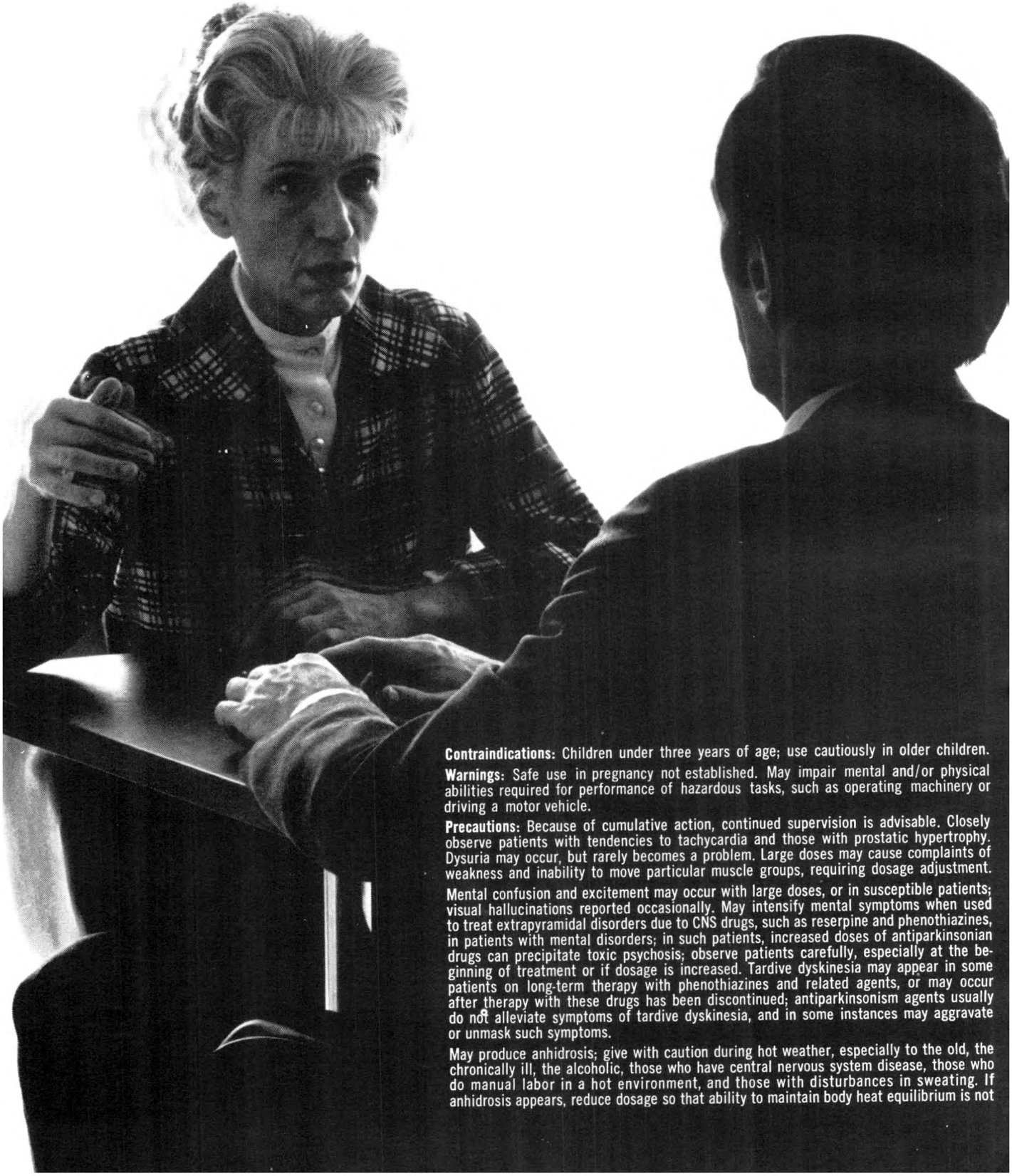
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patients most in need of phenothiazines are often least able to cope with their side effects



Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Tardive dyskinesia may appear in some patients on long-term therapy with phenothiazines and related agents, or may occur after therapy with these drugs has been discontinued; antiparkinsonism agents usually do not alleviate symptoms of tardive dyskinesia, and in some instances may aggravate or unmask such symptoms.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not

TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)
helps alleviate most phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Adverse Reactions: Adverse reactions may be anticholinergic or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Note: Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Patients with a poor mental outlook are usually poor candidates for therapy. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. When benztropine mesylate is used with levodopa the usual dose of each may need to be reduced. Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to the drug.

How Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000; Injection, containing 1.0 mg benztropine mesylate and 9.0 sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
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Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Certain extrapyramidal disorders that develop slowly, such as tardive dyskinesia, usually do not respond to COGENTIN.

For more detailed information, see full prescribing information.

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prepared by

Franklyn N. Arnhoff, Ph.D.

and

A. H. Kumbar

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1. **Supply Characteristics** describes the survey sample in terms of its total number and the percent of response, APA members as well as the number who were in training and those psychiatrists with less than three years' training. It gives data on their age, sex, citizenship, race and work status.
2. **The Education and Training of Psychiatrists** provides data on the number in the sample who graduated from various medical schools by year, the number of years in training, whether the respondent is board certified, etc. All data are analyzed by sex so that this important dimension can be evaluated directly. Data on country of origin of medical school attended are also given for foreign medical graduates.
3. **Professional Activities of Psychiatrists** presents analyses dealing with various aspects of professional practice: where psychiatrists spend their time, how time is allocated, and what they do.
4. **Geographic Distribution of Psychiatrists** presents state totals for the identified manpower pool, along with ratios per 100,000 population.
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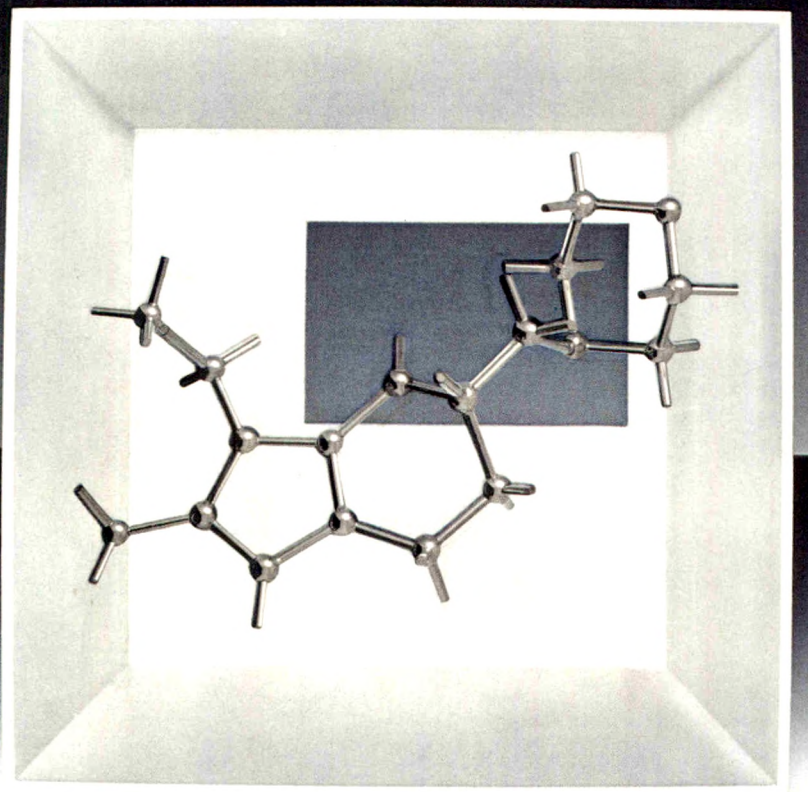
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(molindone HCl)

THE FIRST OF A NEW CLASS OF ANTIPSYCHOTICS TO TREAT THE MANIFESTATIONS OF SCHIZOPHRENIA



CHEMICALLY UNIQUE: MOBAN® is completely unrelated structurally or chemically to any of the three main categories of major antipsychotics currently available.* MOBAN® represents a new class of antipsychotic...the dihydroindolones, oxygenated indole derivatives.

*Please see list of reference literature on comparative studies.

MOBAN® (molindone HCl) PERMITS PATIENT PARTICIPATION AND COOPERATION IN A PROGRAM OF ON-GOING REHABILITATION



CONTROLS SCHIZOPHRENIC SYMPTOMS AS IT MOBILIZES THE PATIENT TOWARD PRODUCTIVE ACTIVITY

At the start of therapy, MOBAN® can often control schizophrenic symptoms. MOBAN® acts rapidly—usually within 2 to 4 weeks—attaining maximum therapeutic benefit by the third treatment month. Once control is achieved, it can often be maintained with MOBAN®. MOBAN® produces increased functional activity which may allow a gradual return to the world the patient has left behind: his family, his job, and his social activities. (Of course, in certain instances where increased activity is contraindicated, caution should be exercised.)

In controlled pre-introductory studies, MOBAN® produced significant improvement of thought, affective, motor, and behavioral disorders.



RAPIDLY AIDS ARREST OF ACUTE OR CHRONIC PSYCHOTIC SYMPTOMS OF SCHIZOPHRENIA

HELPS KEEP PATIENTS ALERT AND RESPONSIVE TO PSYCHOTHERAPY

Because MOBAN® has been shown to produce an increased sense of alertness in some patients, it may be especially useful in those who are withdrawn and apathetic.

MOBAN® (molindone HCl) does not produce the prolonged dulling effects observed with earlier antipsychotics. This lack of continued sedation should make for a more cooperative, better functioning patient...one who will be able to assume a more active role in his over-all rehabilitation, and one less likely



ACTIVATES MANY WITHDRAWN AND APATHETIC PATIENTS

to discontinue the needed maintenance medication. A beneficial sense of well-being occurs in some patients (others may experience an abnormal, exaggerated sense of well-being).

AN EFFECTIVE THERAPEUTIC ALTERNATIVE

When patients are unresponsive or have become refractory to their current medication or suffer certain untoward side effects, MOBAN® offers a clear-cut therapeutic alternative. MOBAN® may be effectively used for the newly diagnosed schizophrenic, on a long-term, in-patient basis, or later on when the patient has assumed an out-patient status. In short, at any step on the way home.

PHARMACOLOGIC PROFILE

The pharmacologic profile of MOBAN® in laboratory animals resembles that of other major antipsychotic agents in that it causes the reduction of spontaneous locomotion and aggressiveness, suppression of conditioned psychotic responses and antagonism of the bizarre, stereotyped behavior and hyperactivity induced by amphetamines. In addition, MOBAN® antagonizes the depression caused by the tranquilizing agent, tetrabenazine.

In human clinical studies, tranquilization is achieved in the absence of muscle relaxing or incoordinating effects. Based on EEG studies, MOBAN® exerts its effects on the ascending reticular activating system.

Human metabolic studies show MOBAN® to reach peak blood levels within one hour after oral administration.

Tolerance has not developed during long-term (3 years) therapy in limited pre-introductory studies.

PLEASE NOTE: Lenticular opacities and skin pigmentation often seen with other currently-prescribed antipsychotics, have not been observed during pre-introductory studies with MOBAN®...making it suitable for those patients from whom other medication should be withdrawn due to those side effects. Such adverse effects result principally from long-term, high dose phenothiazine therapy. The possibility that similar adverse reactions may occur with MOBAN® should be kept in mind.

USUAL DOSAGE RANGES

Initial and maintenance dosages of MOBAN® (molindone HCl) should be individualized, and the minimal effective dose should be employed. Elderly and debilitated patients should be started on lower doses.

Mild 5 mg three or four times a day, up to 15 mg three or four times a day.

Moderate 10 mg three or four times a day, up to 25 mg three or four times a day.

Severe Daily dosages up to 225 mg may be required.

AVAILABLE AS TABLETS IN THREE DOSAGE STRENGTHS



5 mg 10 mg 25 mg

Reference Literature On Comparative Studies

1. Ban, TA; Ramsay, RA; Lehmann, HE: A comparative stu of molindone and trifluoperazine, Curr Ther Res Vol. No. 7, July, 1970 **2.** Brauzer, B and Burton, J: A clinical cor parison of molindone hydrochloride with trifluoperazine psychotic out-patients, Curr Ther Res 13: 152, March, 19 **3.** Clark, M, et al: Molindone in chronic schizophrenia, C Pharm & Ther Vol. 11, No. 5:680-688, Sept.-Oct., 19 **4.** Freeman, H and Frederick, A: Comparison of trifluoper zine & molindone in chronic schizophrenic patients, Cu Ther Res Vol. 11, No. 11:670-676, Nov., 1969 **5.** Hollist LE: Some human pharmacological studies of three ps chotropic drugs: thiothixene, molindone, and W-1867, Clin Pharm Vol. 8:95-101, March—April, 1968 **6.** Itil, T et al: Comparison of the clinical and electroencephal graphical effects of molindone and trifluoperazine acute schizophrenic patients, PDM 3:80, Sept.-Oct., 1970 Goldstein, BJ and Brauzer, B: A clinical comparison of moli done hydrochloride with trifluoperazine in psychotic ou patients, Curr Ther Res Vol. 13, No. 3:152-157, March, 197 **8.** Goldstein, BJ and Brauzer, B: Comparison of molindon and placebo in anxious depressed patients, Curr Ther Re Vol. 3, No. 6:344-349, June, 1971 **9.** Ramsay, RA, et al: A com parison of molindone and trifluoperazine, Curr Ther Re 12:438, July, 1970 **10.** Rickels, K, et al: Molindone and chlo diazepoxide in anxious neurotic out-patients, Curr Ther Re Vol. 14, No. 1:1-9, January, 1972 **11.** Serafetinides, EA, Willis, and Clark, ML: The EEG effects of chemically and clinicall dissimilar antipsychotics—molindone vs. chlorpromazin Int Pharmacopsychiat 6:77-88, 1971 **12.** Simpson, GM, et a A double blind comparison of molindone and trifluoper zine in the treatment of acute schizophrenia. J Clin Pha macol 11:227-236, May-June, 1971.



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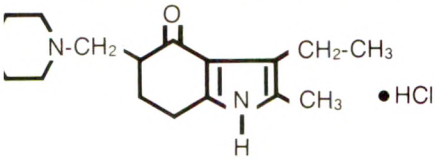
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MOBAN®(molindone HCl)

DESCRIPTION MOBAN® (molindone hydrochloride) is a dihydroindone compound which is not structurally related to the phenothiazines, the butyrophenones or the thioxanthenes.
MOBAN® is 3-ethyl-6, 7-dihydro-2-methyl-5-(morpholinomethyl) indol-4(5H)-one hydrochloride. It is a white crystalline powder, freely soluble in water and alcohol and has a molecular weight of 312.67.



MOLINDONE HYDROCHLORIDE

ACTIONS MOBAN® (molindone hydrochloride) has a pharmacological profile in laboratory animals which predominantly resembles that of major tranquilizers causing reduction of spontaneous locomotion and aggressiveness, suppression of a conditional response and antagonism of the bizarre stereotyped behavior and hyperactivity induced by amphetamines. In addition, MOBAN® antagonizes the depression caused by the tranquilizing agent tetrabenazine.
In human clinical studies tranquilization is achieved in the absence of muscle relaxing or incoordinating effects. Based on EEG studies, MOBAN® exerts its effect on the ascending reticular activating system.
Human metabolic studies show MOBAN® to reach peak blood levels within one hour after oral administration.

INDICATIONS MOBAN® (molindone hydrochloride) is indicated in the management of the manifestations of schizophrenia.

CONTRAINDICATIONS MOBAN® (molindone hydrochloride) is contraindicated in severe central nervous system depression (alcohol, barbiturates, narcotics, etc.) or comatose states, and in patients with known hypersensitivity to the drug.

WARNINGS Usage in Pregnancy Studies in the pregnant patient have not been carried out. Animal reproductive studies have not demonstrated a teratogenic potential. The anticipated benefits must be weighed against the unknown risks to the fetus if used in these patients.

Nursing Mothers Data is not available on the content of MOBAN® (molindone hydrochloride) in the milk of nursing mothers.

Usage in Children Use of MOBAN® (molindone hydrochloride) in children below the age of twelve years is not recommended because safe and effective conditions for its usage have not been established.

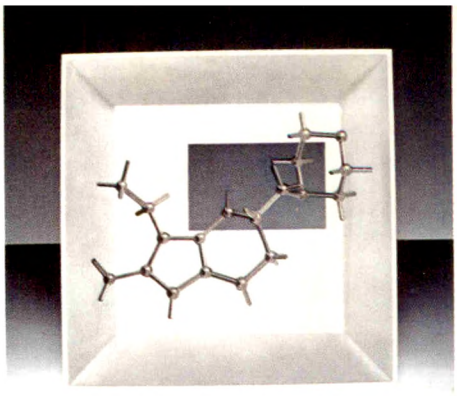
PRECAUTIONS Some patients receiving MOBAN® (molindone hydrochloride) may note drowsiness initially and they should be advised against activities requiring mental alertness until their response to the drug has been established.
Increased activity has been noted in patients receiving MOBAN®. Caution should be exercised where increased activity may be harmful.

ADVERSE REACTIONS Transient initial drowsiness was noted most frequently. Noted less frequently were Parkinsonian reactions (akinesia characterized by rigidity, immobility and reduction of voluntary movement and tremor), akathisia, restlessness, insomnia, depression, feeling of dizziness, blurred vision, hyperactivity, euphoria, dry mouth, headache, nausea and tachycardia. Upon abrupt withdrawal after prolonged high dosage an abstinence syndrome has not been noted.
Others which were observed included weight gain, weight loss, suicidal thinking, postural hypotension, initial heavy menses, amenorrhea, lactation, rash, spasticity, dystonia, akinesia, oculogyric crisis, gastrointestinal upset, increased libido, leukopenia, and nonspecific EKG changes.

ADVERSE REACTIONS NOTED WITH OTHER ANTIPSYCHOTIC AGENTS
The following adverse reactions have been observed with phenothiazine antipsychotic drugs. MOBAN® (molindone hydrochloride) differs chemically and to some degree pharmacologically from phenothiazines, but the possibility that similar adverse reactions may occur with MOBAN® (molindone hydrochloride) should be kept in mind.

Drowsiness Usually mild to moderate, may occur, particularly during the first or second week, after which it generally disappears. If troublesome, dosage may be lowered.

Jaundice Over-all incidence has been low, regardless of indication or dosage. Most investigators conclude it is a sensitivity reaction. Most cases occur between the second and fourth weeks of therapy. The clinical picture resembles infectious hepatitis, with laboratory features of obstructive jaundice, rather than those of parenchymal damage. It is usually promptly reversible on withdrawal of the medication; however, chronic jaundice has been reported. There is no conclusive evidence that pre-existing liver disease makes patients more susceptible to jaundice. Alcoholics with cirrhosis have been successfully treated with phenothiazine, without complications. Nevertheless, the medication should be used cautiously in patients with liver disease. Patients who have experienced jaundice with a phenothiazine should not, if possible, be re-exposed to phenothiazines.
If fever with grippe-like symptoms occurs, test for increased bilirubin or for bile in urine. If tests are positive, stop treatment.
Liver function tests in jaundice induced by the drug may mimic extrahepatic obstruction; withhold exploratory laparotomy until extrahepatic obstruction is confirmed.



Hematological Disorders Including agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura, and pancytopenia, though rare, have been reported.

Agranulocytosis Observe patients regularly for sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears indicate cellular depression, stop treatment and start antibiotic and other suitable therapy.
Most cases have occurred between the 4th and 10th weeks of therapy; patients should be watched closely during that period.

Moderate suppression of white blood cells is not an indication for stopping treatment unless accompanied by the symptoms described above.

Cardiovascular:
Hypotensive Effects Postural hypotension, simple tachycardia, momentary fainting and dizziness may occur after the first injection; occasionally after subsequent injections; rarely after the first oral dose. Usually recovery is spontaneous and symptoms disappear within ½ to 2 hours. Occasionally, these effects may be more severe and prolonged, producing a shock-like condition.

EKG Changes Particularly nonspecific, usually reversible Q and T wave distortions—have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.
Note: sudden death, apparently due to cardiac arrest, has been reported, but there is not sufficient evidence to establish a relationship between such deaths and the administration of the drug.

C.N.S. Effects:
Neuromuscular (Extrapyramidal) Reactions Closely resembling parkinsonism, and motor restlessness have occurred most frequently in psychiatric patients receiving high dosages. Dystonic reactions have been reported occasionally. Such symptoms usually disappear soon after dosage is lowered, the drug temporarily withdrawn, and/or concomitant administration of an anti-parkinsonism agent. (Note: Levodopa has not been found effective in relief of these neuromuscular reactions.) In severe cases suitable supportive measures such as maintaining a clear airway and adequate hydration should be used. When phenothiazine is reinstituted, it should be at a lower dosage.
Hyperreflexia has been reported in the newborn.

Persistent Tardive Dyskinesia As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.
There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.
It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Adverse Behavioral Effects Psychotic symptoms and catatonic-like states have been reported rarely.

Other C.N.S. Effects Cerebral edema has been reported.
Convulsive seizures (petit mal and grand mal) have been reported, particularly in patients with EEG abnormalities or history of such disorders.
Abnormality of the cerebrospinal fluid proteins has also been reported.

Allergic Reactions Of a mild urticarial type of photosensitivity are seen. Avoid undue exposure to sun. More severe reactions, including exfoliative dermatitis, have been reported occasionally.

Endocrine Disorders Lactation and moderate breast engorgement may occur in females on large doses. If persistent, lower dosage or withdraw drug. False positive pregnancy tests have been reported, but are less likely to occur when a serum test is used. Amenorrhea and gynecomastia have also been reported. Hyperglycemia, hypoglycemia and glycosuria have been reported.

Autonomic Reactions Occasional dry mouth; nasal congestion; constipation; adynamic ileus; urinary retention; miosis and mydriasis.

Special Considerations in Long-Term Therapy Skin pigmentation and ocular changes have occurred in some patients taking substantial doses of phenothiazines, for prolonged periods.

Skin Pigmentation Rare instances of skin pigmentation have been observed in hospitalized mental patients, primarily females who have received the drug usually for three years or more in higher dosages. The pigmentary changes, restricted to exposed areas of the body, range from an almost imperceptible darkening of the skin to a slate gray color, sometimes with a violet hue. Histological examination reveals a pigment, chiefly in the dermis, which is probably a melanin-like complex. The pigmentation may fade following discontinuance of the drug.

Ocular Changes Ocular changes have occurred more frequently than skin pigmentation and have been observed both in pigmented and nonpigmented patients receiving phenothiazines, usually for two years or more. Eye changes are characterized by deposition of fine particulate matter in the lens and cornea. In more advanced cases, star-shaped opacities have also been observed in the anterior portion of the lens. The nature of the eye deposits has not yet been determined. A small number of patients with more severe ocular changes have had some visual impairment. In addition to these corneal and lenticular changes, epithelial keratopathy and pigmentary retinopathy have been reported. Reports suggest that the eye lesions may regress after withdrawal of the drug.
Since the occurrence of eye changes seems to be related to dosage levels and/or duration of therapy, it is suggested that long-term patients on moderate to high dosage levels have periodic ocular examinations.

Etiology The etiology of both of these reactions is not clear, but exposure to light, along with dosage/duration of therapy, appears to be the most significant factor. If either of these reactions is observed, the physician should weigh the benefits of continued therapy against the possible risks and, on the merits of the individual case, determine whether or not to continue present therapy, lower the dosage, or withdraw the drug.

Other Adverse Reactions Mild fever may occur after large I.M. doses. Hyperpyrexia has been reported. Increases in appetite and weight sometimes occur. Peripheral edema and a systemic lupus erythematosus-like syndrome have been reported.
Note: There have been occasional reports of sudden death in patients receiving phenothiazines. In some cases, the cause appeared to be asphyxia due to failure of the cough reflex. In others, the cause could not be determined. There is not sufficient evidence to establish a relationship between such deaths and the administration of phenothiazines.

DOSAGE AND ADMINISTRATION Initial and maintenance doses of MOBAN® (molindone hydrochloride) should be individualized, and the minimal effective dose should be employed. Elderly and debilitated patients should be started on lower dosage.

Dosage schedule, based on severity of symptomatology
1. Mild—5 mg three or four times a day; an increase to 15 mg three or four times a day may be required.
2. Moderate—10 mg three or four times a day; an increase to 25 mg three or four times a day may be required.
3. Severe—daily dosage as high as 225 mg may be required.

DRUG INTERACTIONS Potentiation of drugs administered concurrently with MOBAN® (molindone hydrochloride) has not been reported. Additionally, animal studies have not shown increased toxicity when MOBAN® is given concurrently with representative members of three classes of drugs (i.e., barbiturates, chloral hydrate and antiparkinson drugs).

MANAGEMENT OF OVERDOSAGE Symptomatic, supportive therapy should be the rule.
Gastric lavage is indicated for the reduction of absorption of MOBAN® (molindone hydrochloride) which is freely soluble in water.
Since the absorption of MOBAN® (molindone hydrochloride) by activated charcoal has not been determined, the use of this antidote must be considered of theoretical value.
Emesis in a comatose patient is contraindicated. Additionally, while the emetic effect of apomorphine is blocked by MOBAN® in animals, this blocking effect has not been determined in humans.
A significant increase in the rate of removal of unmetabolized MOBAN® from the body by forced diuresis, peritoneal or renal dialysis would **not** be expected. (Only 2% of a single ingested dose of MOBAN® is excreted unmetabolized in the urine.) However, poor response of the patient may justify use of these procedures. While the use of laxatives or enemas might be based on general principles, the amount of unmetabolized MOBAN® in feces is less than 1%.
Extrapyramidal symptoms have responded to the use of diphenhydramine (Benadryl*) and the synthetic anticholinergic antiparkinson agents, (i.e., Artane*, Cogentin*, Akineton*).

HOW SUPPLIED As tablets in bottles of 100 and 1000 with potencies and colors as follows:

5 mg orange	*Benadryl—Trademark, Parke Davis and Co.
10 mg lavender	*Artane—Trademark, Lederle Laboratories
25 mg light green	*Cogentin—Trademark, Merck Sharp & Dohme
	*Akineton—Trademark, Knoll Pharmaceutical Co.

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Subsidiary of E.I. du Pont de Nemours & Co. (Inc.)
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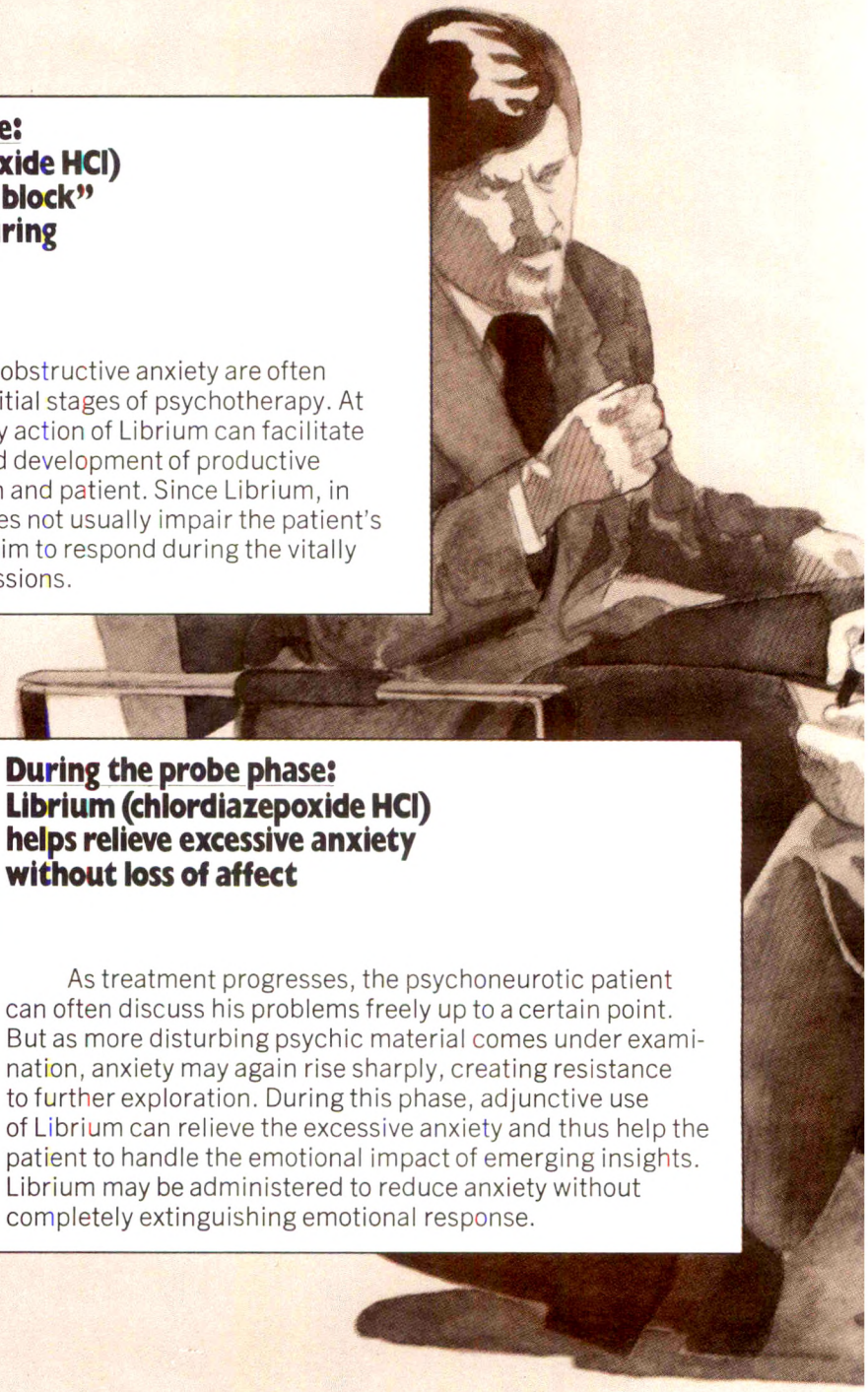
18 Dosage Forms and Strengths

Tablets—10, 25, 50, 100 and 200 mg.
Spansule® capsules—30, 75, 150, 200 and 300 mg.
Injection—25 mg./ml.
Syrup—10 mg./5 ml.
Suppositories—25 and 100 mg.
Concentrate—30 and 100 mg./ml.
Single Unit Packages—10, 25, 50, 100 and 200 mg. tablets;
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Indicated particularly during critical



During the entry phase:
Librium (chlordiazepoxide HCl) helps reduce "anxiety block" usually without impairing mental acuity

Heightened levels of obstructive anxiety are often encountered during the initial stages of psychotherapy. At such times, the antianxiety action of Librium can facilitate verbal communication and development of productive rapport between physician and patient. Since Librium, in recommended dosage, does not usually impair the patient's mental acuity, it enables him to respond during the vitally important introductory sessions.

During the probe phase:
Librium (chlordiazepoxide HCl) helps relieve excessive anxiety without loss of affect

As treatment progresses, the psychoneurotic patient can often discuss his problems freely up to a certain point. But as more disturbing psychic material comes under examination, anxiety may again rise sharply, creating resistance to further exploration. During this phase, adjunctive use of Librium can relieve the excessive anxiety and thus help the patient to handle the emotional impact of emerging insights. Librium may be administered to reduce anxiety without completely extinguishing emotional response.

Before prescribing, please consult complete product information, a summary of which follows:

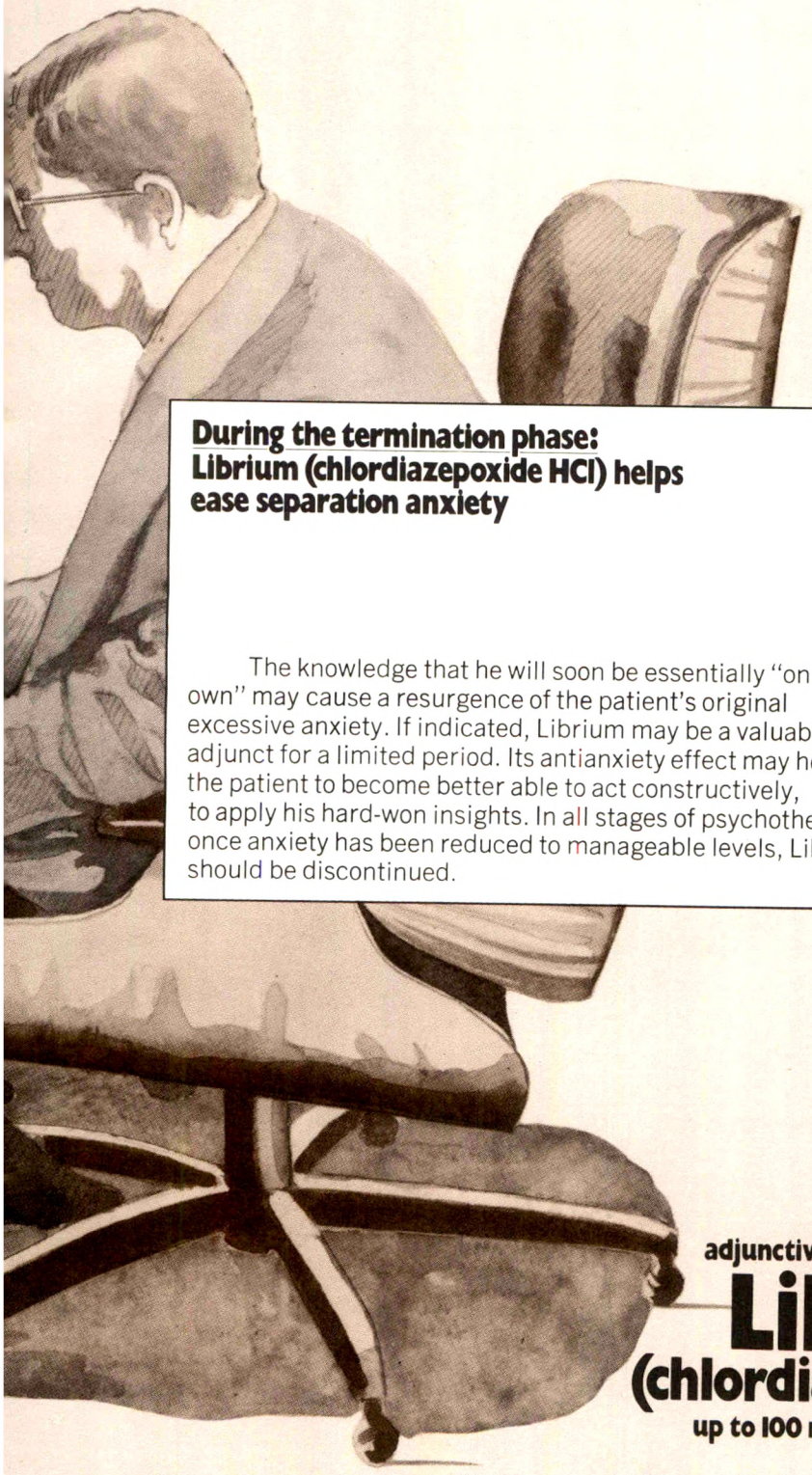
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have

anxiety phases of psychotherapy



During the termination phase:
Librium (chlordiazepoxide HCl) helps ease separation anxiety

The knowledge that he will soon be essentially "on his own" may cause a resurgence of the patient's original excessive anxiety. If indicated, Librium may be a valuable adjunct for a limited period. Its antianxiety effect may help the patient to become better able to act constructively, to apply his hard-won insights. In all stages of psychotherapy, once anxiety has been reduced to manageable levels, Librium should be discontinued.

adjunctive ROCHE

Librium® 10 mg, 25 mg capsules
(chlordiazepoxide HCl)
up to 100 mg daily in severe anxiety

een reported in psychiatric patients and yperactive aggressive children. Employ usual recautions in treatment of anxiety states with vidence of impending depression; suicidal ndencies may be present and protective easures necessary. Variable effects on blood oagulation have been reported very rarely in atients receiving the drug and oral anticoagu- nts; causal relationship has not been estab- shed clinically.

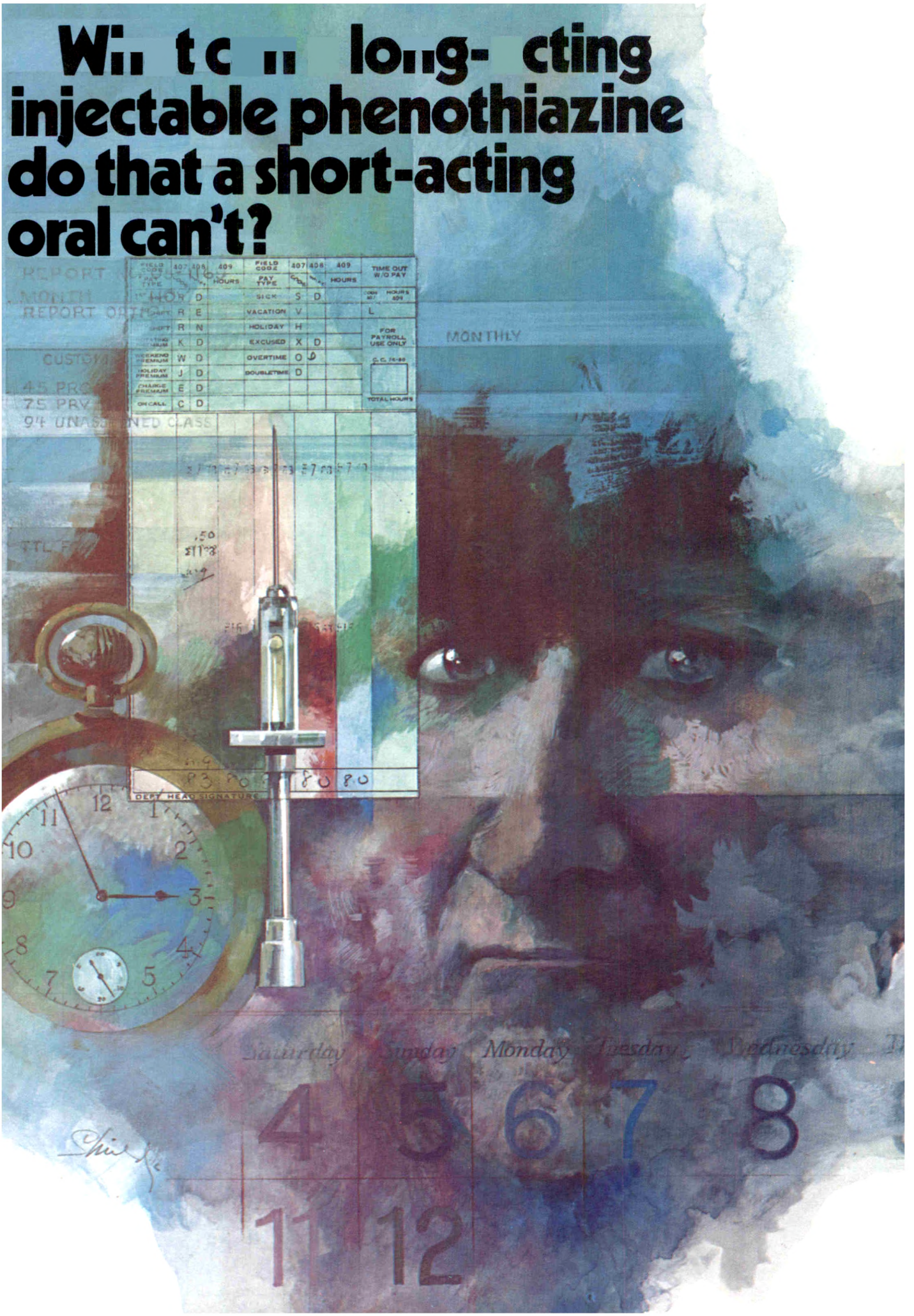
Adverse Reactions: Drowsiness, ataxia and nfusion may occur, especially in the elderly nd debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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It can save time, it can save money, and it can even save people – by reducing readmissions.

Time Prolixin Decanoate (Fluphenazine Decanoate Injection), with duration of action that may last up to 4 weeks or longer in patients on maintenance therapy, can effect important savings in nursing time.

Approximate Staff Time Required to Medicate 18 Schizophrenic Patients*

8 a.m. ¾ hr. 1 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 28 days for most patients
= 2¼ hours nursing time	4 minutes required for each injection
2¼ hrs. x 28 days = 63 hours of nursing time every 28 days	= 1 hr., 10 minutes nursing time in 28 days
NURSING TIME SAVED IN 28 DAYS	61 hours and 50 minutes or more than 7½ eight-hour working days

*Adapted from Platt R: Br J Social Psychiatry 2: 187-191, 1968.

Money Martin and Townend[1], who found from their study of Prolixin Decanoate that 15 of 39 patients could be maintained on 25 mg. every 4 weeks, also note that on this basis "a year's maintenance on chlorpromazine represents the order of 110 grams of phenothiazine as opposed to 0.33 gram of fluphenazine." Translating this into dollars shows the following potential hospital savings on the basis of patient population:

Agent and amount/year	Form	Cost/patient/ year	Cost/500 patients/ year
Chlorpromazine (SKF brand) 110 grams	8 oz. concentrate 100 mg./ml.†	$48.75*	$24,375
Prolixin Decanoate .33 grams	5 ml. vials 25 mg./ml.	23.17**	11,585
SAVINGS		$25.58 patient, year	$12,790 500 pts/yr

* Calculated from prices published in 1975 Red Book.
** Calculated from Squibb 1975 price catalogue.
† With tablets, the annual cost is even greater.

People The controlled drug delivery system of Prolixin Decanoate helps get schizophrenic patients out of the hospital and helps them stay out. It promotes continuity of therapy—reducing outpatient drug defaulting from approximately 50% with oral medications according to one report[2] to about 16% according to another report[3].

It reduces the number and length of rehospitalizations. In one study of 103 patients maintained on injections of long-acting fluphenazines, total hospital readmissions for a year were cut from 191 to 50 and inpatient time from 8,713 days to 1,335 days[4].

It facilitates return to a productive life. A 12-month followup of 103 discharged patients revealed 77% in full-time employment or household duties and only 23% unemployed[4].

PROLIXIN DECANOATE®

(Fluphenazine Decanoate Injection)

may control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

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References:

1. Martin ICA and Townend RA: Brit J Psychiat 124: 173-6, 1974.
2. Goldberg HL, DiMascio A, Chaudhary B: Psychosomatics 11: 173-177, 1970.
3. Medical World News, February 11, 1972, p. 58H.
4. Denham J and Adamson L: Can Psychiat Assoc J 18: 235-7, 1973.

For product brief summary see following page.

H425-001R

PROLIXIN DECANOATE®

Fluphenazine Decanoate Injection)

ay control schizophrenic symptoms for up to 4 weeks or longer in patients on maintenance therapy.

olixin Decanoate (Fluphenazine Decanoate Injection) provides mg. fluphenazine decanoate per ml. In a sesame oil vehicle with % (w/v) benzyl alcohol as a preservative.

NTRAINDICATIONS: In presence of suspected or established subtical brain damage. In patients who have a blood dyscrasia, liver nage or renal insufficiency, or who are receiving large doses of notics, or who are comatose or severely depressed. In patients who e shown hypersensitivity to fluphenazine; cross-sensitivity to phehiazine derivatives may occur.
Not intended for use in children under 12.

RNINGS: Mental and physical abilities required for driving a car operating heavy machinery may be impaired by use of this drug. ysicians should be alert to the possibility that severe adverse reions may occur which require immediate medical attention. Potentian of effects of alcohol may occur. Safety and efficacy in children e not been established because of inadequate experience in use hildren.

sage in Pregnancy: Safety for use during pregnancy has not been ablished; weigh possible hazards against potential benefits if adnistering this drug to pregnant patients.

ECAUTIONS: Caution must be exercised if another phenothiazine mpound caused cholestatic jaundice, dermatoses or other allergic actions because of the possibility of cross-sensitivity. When psychotic lents on large doses of a phenothiazine drug are to undergo surgery, otensive phenomena should be watched for; less anesthetics or ntral nervous system depressants may be required. Because of added icholinergic effects, fluphenazine may potentiate the effects of opine.
Use fluphenazine decanoate cautiously in patients exposed to exme heat or phosphorus insecticides; in patients with a history of nvulsive disorders since grand mal convulsions have occurred; and patients with special medical disorders such as mitral insufficiency other cardiovascular diseases, and pheochromocytoma. Bear in nd that with prolonged therapy there is the possibility of liver damage, imentary retinopathy, lenticular and corneal deposits, and developint of irreversible dyskinesia.
Fluphenazine decanoate should be administered under the direction a physician experienced in the clinical use of psychotropic drugs. riodic checking of hepatic and renal functions and blood picture ould be done. Renal function of patients on long-term therapy should monitored; if BUN becomes abnormal, treatment should be distinued. "Silent pneumonias" are possible.

VERSE REACTIONS: *Central Nervous System*—Extrapyramidal mptoms are most frequently reported. These include pseudoparkinism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, d hyperreflexia; most often these are reversible, but they may be sistent. One can expect a higher incidence of such reactions with phenazine decanoate than with less potent piperazine derivatives straight-chain phenothiazines. The incidence and severity will dend more on individual patient sensitivity, but dosage level and patient e are also determinants. As these reactions may be alarming, the tient should be forewarned and reassured. These reactions can usually controlled by administration of antiparkinsonian drugs such as benzpine mesylate or intravenous Caffeine and Sodium Benzoate Injecn U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, pertent and sometimes irreversible tardive dyskinesia may appear in me patients on long-term therapy or may occur after discontinuation drug. The risk seems greater in elderly patients, especially females, high dosages. The syndrome is characterized by rhythmical involuny movements of tongue, face, mouth, or jaw (e.g., protrusion of ngue, puffing of cheeks, puckering of mouth, chewing movements) d may be accompanied by involuntary movements of extremities. ere is no known effective therapy for tardive dyskinesia; usually the mptoms are not alleviated by antiparkinsonism agents. If the symptoms pear, discontinuation of all antipsychotic agents is suggested. The ndrome may be masked if treatment is reinstituted, or drug dosage creased, or a different antipsychotic agent used. Reports are that e vermicular movements of the tongue may be an early sign of the ndrome which may not develop if medication is stopped at that time. Phenothiazine derivatives have been known to cause restlessness, citement, or bizarre dreams; reactivation or aggravation of psychotic ocesses may be encountered. If drowsiness or lethargy occur, the sage may have to be reduced. Dosages, far in excess of the recomended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood essure have been reported. Although hypotension is rarely a prob-m, patients with pheochromocytoma, cerebral vascular or renal inficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 ml. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 ml. vials.

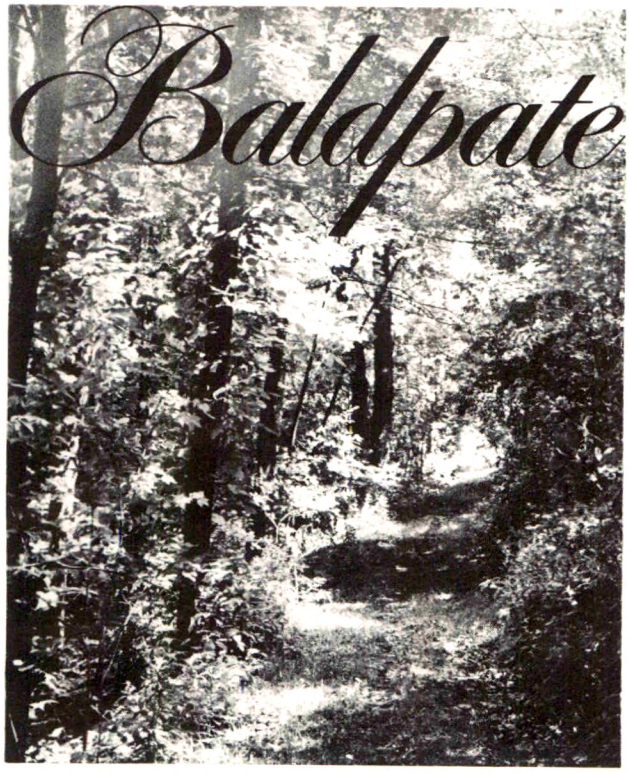
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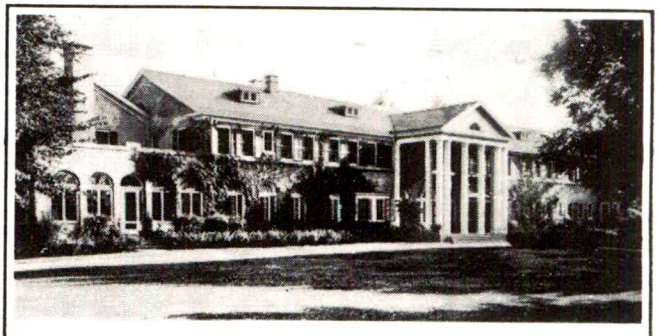
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Consider the advantages of starting her on HALDOL® (haloperidol)

Acts promptly to improve disordered thought and perception

HALDOL haloperidol has been found highly effective in reducing or eliminating delusions and hallucinations, even in some patients refractory to previous drug therapy.[1-6] Symptom control is achieved rapidly, with many patients showing distinct improvement in a few days to a week[1,6]—frequently within a few hours when the intramuscular form is used for initial control of acutely agitated psychotic states.[7,8]

Usually leaves patients relatively alert and responsive

Although some instances of drowsiness have been observed, marked sedation with HALDOL haloperidol is rare. In fact, this drug has been reported to increase activity in some underactive patients, while in hyperactive patients it usually reduces activity to a normal level without somnolence. HALDOL haloperidol has been found to "normalize" behavior and produce a sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.[5]

Reduces likelihood of certain adverse reactions

HALDOL haloperidol, a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. The most commonly noted side effects of HALDOL haloperidol—extrapyramidal reactions—are usually dose-related and readily controlled with antiparkinson drugs.

Transient hypotension occurs rarely; severe orthostatic hypotension has not been reported. HALDOL haloperidol is also unlikely to cause hepatic damage, serious hematologic reactions, photosensitivity reactions and skin rashes. Ocular damage and pigmentation changes have not been reported.

References: 1. Towler, M.L., and Wick, P.H.: Int. J. Neuropsychiat. 3: Suppl. 1,62 (Aug.) 1967. **2.** Ban, T.A., and Lehmann, H.E.: Int. J. Neuropsychiat. 3: Suppl. 1,79 (Aug.) 1967. **3.** Yun, B.S., et al.: Mich. Med. 67:1349 (Nov.) 1968. **4.** Gerle, B.: Clin. Trials J. 3:380 (Feb.) 1966. **5.** Haward, L.R.C.: Clin. Trials J. 2:135 (May) 1965. **6.** Rubin, R.: Alabama J. Med. Sci. 8:414 (Oct.) 1971. **7.** Man, P.L., and Chen, C.H.: Psychosomatics 14:59 (Jan.-Feb.) 1973. **8.** Palestine, M.L., and Alatorre, E.: Quart. J. Stud. Alcohol 34:185 (Mar.) 1973.

HALDOL®
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tablets/concentrate/injection

highly specific control of disordered and disruptive behavior

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

IMPORTANT: Full directions for use should be read before HALDOL haloperidol is administered or prescribed.

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A Dosage Form for Every Need:



5 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg., 5 mg. and 10 mg.



An undetectable, tasteless liquid concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.



A rapid-acting injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Indications: HALDOL haloperidol is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome.

Contraindications: HALDOL haloperidol is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL haloperidol in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of haloperidol orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL haloperidol, decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL haloperidol may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL haloperidol should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, epinephrine should not be used since HALDOL haloperidol may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL haloperidol may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant antiparkinson medication is required, it may have to be continued after HALDOL haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including antiparkinson agents, are administered concomitantly with HALDOL haloperidol. When HALDOL haloperidol is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

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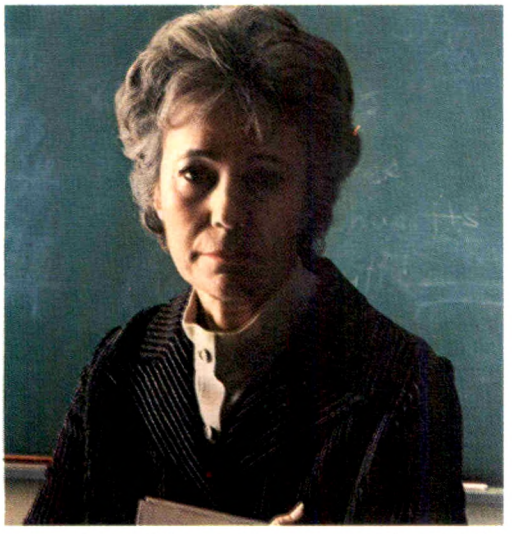
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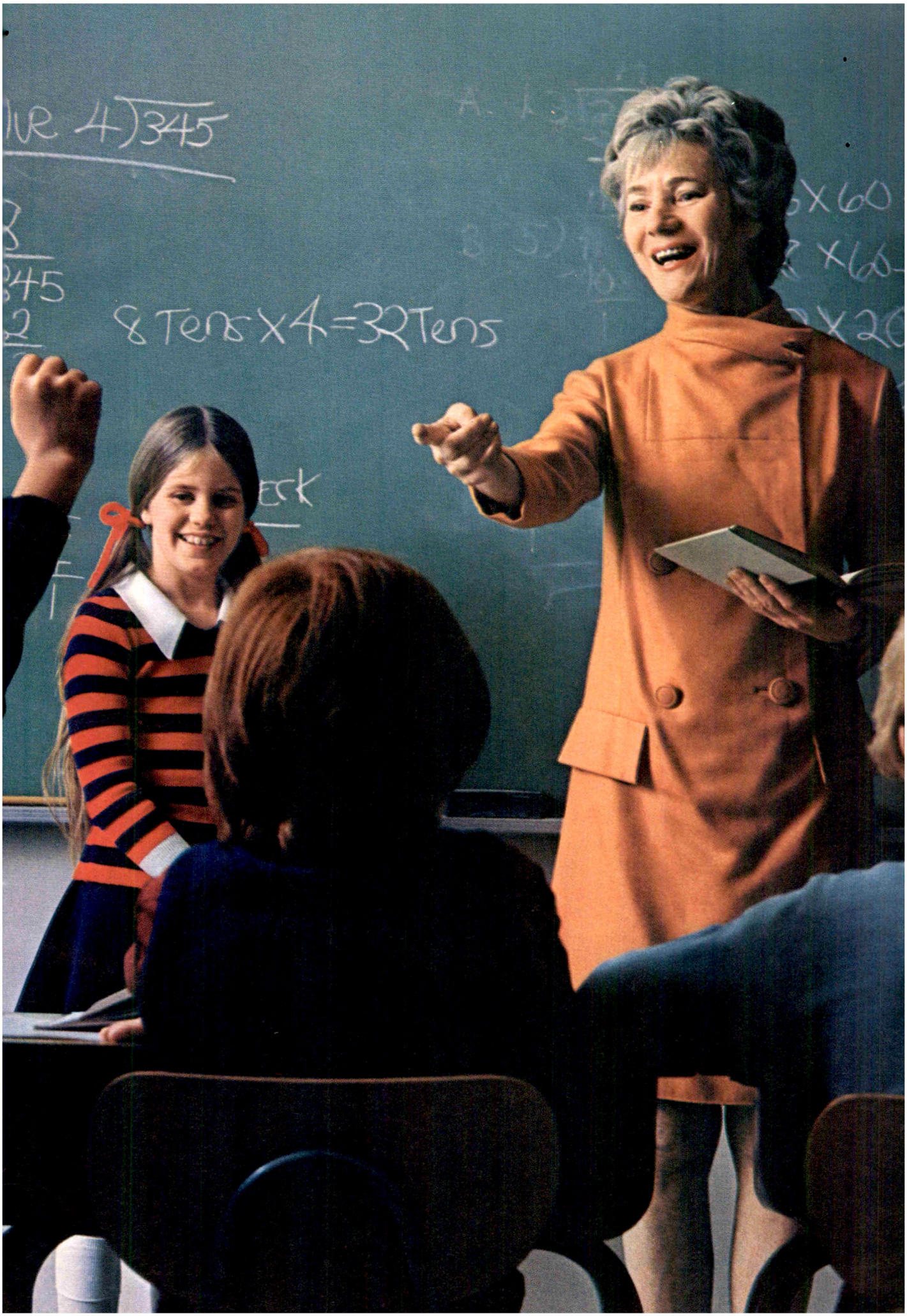
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Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed.

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period – withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

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References: 1. Kaufman, S.A.: Obstet. Gynecol. *30*:399 (Sept.) 1967. 2. McEwen, D.C.: Can. Nurse *63*:34 (Feb.) 1967. 3. Kaufman, S.A., in Olds, S.: Today's Health 48:48 (May) 1970. 4. Klaiber, E.L., *et al.*: Am. J. Psychiatry *128*:1492 (June) 1972. 5. Rhoades, F.P.: Mich. Med. 64:410 (June) 1965. 6. Rhoades, F.P.: J. Am. Geriatr. Soc. *15*:346 (Apr.) 1967. 7. Kerr, M.D.: Mod. Treat. 5:587 (May) 1968. 8. Tramont, C.B.: Geriatrics *21*:212 (Nov.) 1966. 9. Kupperman, H.S.: Med. Aspects Hum. Sexuality *1*:64 (Sept.) 1967. 10. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, chap. 69, p. 1538 ff.

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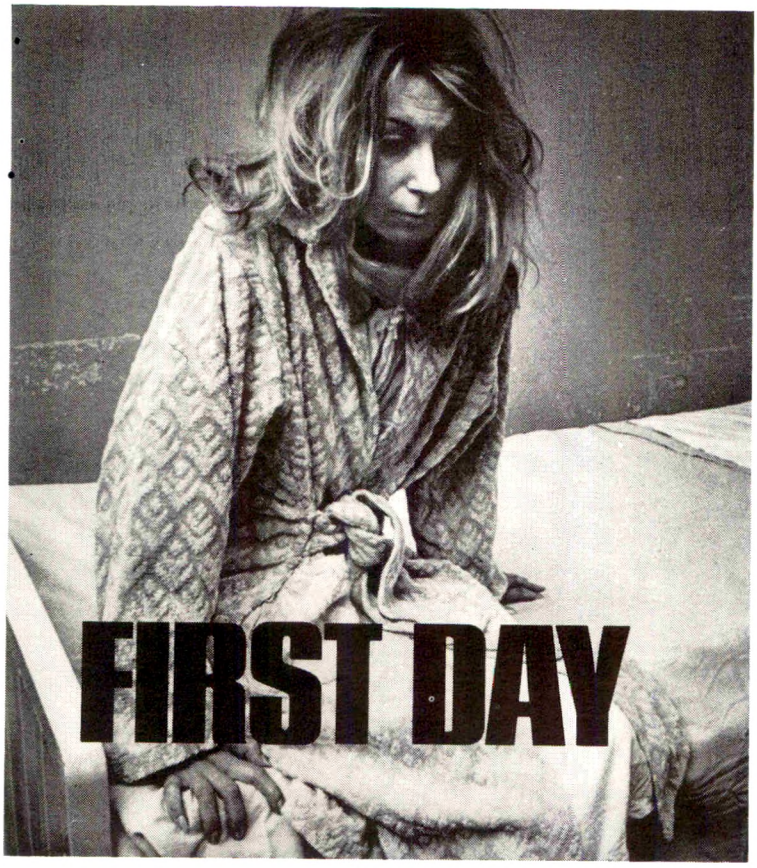
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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy, observed primarily in patients receiving larger than recommended doses, is characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision; the possibility of its occurrence may be reduced by remaining within recommended dosage limits. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; rarely, nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—Rare cases described as parotid swelling. The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea; systemic lupus erythematosus-like syndrome.

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THE AMERICAN JOURNAL OF PSYCHIATRY

Marital Therapy from a Psychiatric Perspective: An Overview

BY ELLEN M. BERMAN, M.D., AND HAROLD I. LIEF, M.D.

The authors describe various methods of marital therapy in use today. Although absence of a unifying conceptual scheme in the past has hampered developments in this field, the increasing acknowledgment by psychiatrists of the important effect of the environmental system on thoughts, feelings, and behavior has facilitated a therapeutic approach stressing not only a person's intrapsychic conflicts but current environmental, family, and spouse-related phenomena. The authors discuss three dimensions of marital psychodynamics—power, intimacy, and marital boundary setting—and relate them to the marital life cycle and to four classifications of the marital relationship: 1) rules for defining power, 2) parental stage, 3) level of intimacy, and 4) personality style and psychiatric terminology. The paper includes a brief discussion of therapy techniques, sex counseling, the use of cotherapists, the future of marriage, and alternative lifestyles.

AMONG THE PROLIFERATING forms of psychiatric therapy in the last decade, marital and dyadic therapy have assumed an ever-increasing importance. Marital problems of patients have always been a significant consideration for psychiatrists and psychotherapists. A survey by Sager and associates (1) demonstrated that 50 percent of the patients requesting psychotherapy did so largely because of marital difficulties, and another 25 percent had problems related to marriage. According to Gurin and associates (2), among the reasons why people seek help for emotional problems, marital concerns rank first, followed by other family problems. Nevertheless, until the middle of the last decade few psychiatrists specialized in marital therapy (3), and little training in marital therapy was available to psychiatric residents (4).

This paper was written at the invitation of the Editor.

Dr. Berman is Assistant Professor and Dr. Lief is Professor, Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.; they are also with the Department's Division of Family Study, where Dr. Berman is Chief of Counseling Services and Dr. Lief is Director. Address reprint requests to Dr. Berman, Division of Family Study, 4025 Chestnut St., Room 210, Philadelphia, Pa. 19104.

RESISTANCE OF PSYCHIATRISTS TO MARITAL THERAPY

The one-to-one doctor-and-patient model of therapy is ingrained in medical-student teaching. In psychiatry this perspective has been augmented by the psychoanalytic dictum that the relationship between the doctor and the patient will be attenuated and the transference diluted if the therapist sees other family members. In addition, psychoanalysis and psychodynamic psychotherapy (at least in the past) tended to emphasize intrapsychic rather than interpersonal problems, so that many therapists felt incompetent and uncomfortable in dealing with more than one patient at a time.

Although the more eclectic training programs have recognized that systems or transactional issues are valid areas of therapeutic exploration, they have usually emphasized one-to-one treatment and the use of transference phenomena as a means of effecting change in the dyad. The therapist, therefore, may avoid dyadic couples' therapy even when he feels that such techniques might be indicated. In addition, many psychiatrists felt that their professional status might be threatened because of the insufficient status assigned to the field of marriage counseling, a field that comprises practitioners from a variety of disciplines with different perspectives and methods of treatment (5–7).

The absence of a unifying conceptual scheme and the complexities and difficulties of developing a suitable diagnostic classification also inhibited psychiatrists who otherwise might have been led into the field. At the present time there is enough information on new concepts dealing with possible conceptual schemes and diagnostic classifications to warrant reconsideration. This paper will tie together the multiple models of dyadic therapy that form the framework for the therapeutic intervention and will, in addition, discuss methods of marital therapy.

DEFINITIONS OF MARRIAGE COUNSELING AND MARITAL THERAPY

Even if the terms "marriage counseling" and "marital therapy" (8) often have been used interchangeably, it is important to assess their differences and similarities. Marriage counseling has traditionally included a broad range of activities, from giving advice about financial affairs or how to deal with in-laws to a sophisticated analysis of the transactional processes between the husband and wife. We define marital therapy to include all of these counseling activities and, in addition, the use of unconscious processes such as those manifested in symptom formation, dreams, fantasies, and slips of the tongue, together with a more thorough consideration of individual psychopathology.

In marital therapy the therapist brings to bear his full range of skills, depending on his knowledge of individual and transactional psychodynamics, making use of transference manifestations as well as unconscious factors (internal conflicts and defenses) in making his appraisal and choosing his therapeutic interventions. Marital therapy may include behavioral techniques that make little or no use of unconscious processes but take into account the subtleties and nuances of the transactions between the spouses. In contrast to individual psychotherapy, which emphasizes intrapsychic factors, marital therapy focuses primarily on interpersonal relationships.

The psychiatrist who is trained in both individual and marital psychotherapy is in a particularly advantageous position, for he has the capacity to shift between intrapsychic and interpersonal factors—a skill that those trained in only one of these modalities lack. The interrelationships between intrapsychic and interpersonal factors are the heart of marital therapy. Confusion about marital therapy exists because many professionals who practice it do not take cognizance of unconscious or transference issues and are not always concerned with matters of diagnosis and individual dynamics. There are others who do not simply disregard these issues—they claim that consideration of individual dynamics, even pathology, and diagnosis interferes with the effective treatment of a marital couple.

EMERGING TRENDS

Despite its diverse background, marriage counseling seems to be developing a growing professional organization and identity as a separate discipline (9–16). The American Association of Marriage and Family Counselors has doubled its membership in the last 5 years. The total literature devoted to marital therapy has also doubled in the last few years (17, 18), indicating a sharply increasing interest among professionals in this field. Special journals such as *The Journal of Marriage and the Family, The Family Coordinator*, and *Family Process*, as well as two new ones, *The Journal of Marital and Sexual Therapy* and *The Journal of Marriage and Family Counseling*, also indicate the growth of the field.

Training in marital therapy in medical schools has also noticeably increased. Martin and Lief (4) have reported that 50 percent of the medical schools in the United States include marital therapy in the training of psychiatric residents. Thus the "illegitimate child" of a multidisciplinary union not only is growing rapidly but is achieving legitimacy through professional organizations and new journals, by increasing numbers of research reports and practitioners, and by the stepped-up training of psychiatric residents. Despite these trends, however, training in marital therapy is still inadequate, and only a few centers in the United States provide adequate formal, supervised clinical experience.

CONCEPTUAL SCHEMES IN THERAPY

Although there is still much confusion over conceptual schemes in marital therapy, one factor is achieving wider recognition, namely, the effect of the environmental system on thoughts, feelings, and behavior (19). As increasingly successful techniques have developed involving symptom removal by changing the transactional system, it has become apparent that behavior is motivated not only by underlying intrapsychic conflicts but by feelings and attitudes involving the dyad as well as the family and the environment (20–25). Therefore, marital therapy must be related not only to a person's intrapsychic conflicts but, more importantly, to current environmental, family, and spouse-related phenomena.

Conceptual schemes for dyadic relationships are clearly in their infancy. Over the last 30 years many clinicians, from Sullivan (26) and Spiegel (27) to Minuchin (28), have attempted to describe the complicated framework of interpersonal patterns of communication. But there has been no system that satisfactorily explains the multiple variables and complicated processes involved, at least in operational terms. Three of the most helpful approaches (29) have centered on the following factors:

1. How we communicate: the rules or formal aspects of communication most eloquently described by systems and communications analysis.
2. What we communicate: primarily issues of role expectations and behavior based on social-psychological concepts.
3. Why we communicate: motivational factors based on the more traditional psychodynamic approaches to internal conflict usually related to early childhood experiences and learning.

A prominent problem in marital therapy has been to distinguish severe characterological pathology, for which the best treatment is long-term psychotherapy (30), from behavior determined by pathological transactions, which is modifiable by changes in the transactional system. In this respect a systems-behavioral approach is particularly helpful because it gives clues as to what in the current environmental system may give rise to dysfunctional or disturbed behavior.

We have linked the systems and behavioral approaches because both concentrate on observable behavior and

rules of current communication (31–34), without immediate recourse to a historical "why" (always mindful of the potential understanding provided by the ontogenetic method, e.g., the similarity of spouse- and parent-related behavior).

Behavior therapy describes the rules by which certain behaviors can be learned, reinforced, or extinguished, regardless of the original reason for the behavior (35–38). It provides a theoretical basis for the commonsense knowledge that even simple behavioral changes can sometimes evoke major alterations in the behavior and feelings of the spouse or children, thus substantiating the findings of social psychologists that behavioral changes usually precede attitudinal ones.

Systems theory aids our perspective with the postulate that in any system, the whole is not simply the sum of its parts but an integrated entity (39). The parts of the system are so interrelated that a change in one causes changes in all. Thus the relationships are not simply linear but, by means of feedback loops, circular and continuous with no beginning or end. In the process of being a positive or negative reinforcer, the person producing change is himself changed.

Although further discussion of this complicated subject is beyond the scope of this paper, we have found that many of the postulates of systems theory are helpful (40–43). Conceptually, the marital dyad is an open system that is in (easy or uneasy) equilibrium with its environment. Once children enter the picture, the system enlarges. Minuchin (28) has described the enlarged system particularly well within the context of structural family therapy. As marital-change agents, however, we often find it useful to separate the marital dyad from the family system, recognizing and dealing with the other elements in the system when necessary.

MARITAL PSYCHODYNAMICS

Marital or dyadic relationships involve three critical dimensions that are similar to those explicated for group process, as follows:

1. Power: Who is in charge? (It is commonplace now to point out how often the submissive, weak, or sick partner exerts control and power over the "dominant," decision-making spouse.)
2. Intimacy: How near, how far? (The vacillations in emotional and geographic distance, as partners struggle with their need for and fear of closeness, are significant data for the marital therapist. Coming close and separating again and again is a dialectical feature of life, which became the cornerstone of Rank's theories [44].)
3. Inclusion-exclusion: Who else is considered to be part of the marital system? (This applies not only to in-laws or the extended family but to friends, careers, recreational and social activities, and even pets.)

All relationships must in some way come to terms with these issues. The ways in which these fundamental human questions are solved depend on intrapsychic processes and marital style (see the section on Systems of Marital Classification and Diagnosis). In healthy relationships the solutions are not static but instead are in continuous flux, depending on the stage and needs of the couple. Dysfunctional couples tend to erect more static and rigid solutions.

The dynamic forces in the marriage result from each spouse's need to achieve his/her expectations (certain levels of power, intimacy, and boundary setting), offset and opposed by the need to compromise or submerge these desires in order to enable the partner to attain his/her expectations. The balance between the struggle for autonomous self-fulfillment and the need to please the partner or aid the relationship whenever these are opposing or uncomplementary forces is not only the heart of the marriage but the core of marital therapy.

Because one's own needs and desires are often contradictory, internal conflict is inevitable. The complexity of the interpersonal situation is augmented by the presence of internal conflict in one of the spouses. Internal conflict leads to the sending out of conflicting messages or ambiguous and confusing role behavior, hence the need for attention to patterns of communication in marital therapy (12, pp. 3–20). In order to effect change, the individual and internal conflicts of each partner must also be carefully examined. In the end, in some marriages fundamental changes in behavior depend on a change in the individual personality structure of one or both of the partners involved. However, until the structure—the what and how—of communication is carefully appraised and classified, the adequate separation and exploration of intrapsychic processes are almost impossible.

THE MARITAL LIFE CYCLE

Individual and marital development are inexorably entwined. The marital life cycle is best examined in light of the recent research on adult development by Levinson and coworkers (45) and by Gould (46), which builds on Erikson's theories of psychosocial development (47); these authors have developed a series of normative stages in the adult life cycle. In table 1 we have attempted to relate the marital life cycle to individual developmental tasks and stages, as set forth principally by Levinson and associates (45). Butler (48), Neugarten and Datan (49), and Lidz (50) have also done work in this area.

The individual and the marital life cycles can be divided into seven stages, as indicated in table 1. Any such graphic description of complicated life events is bound to be schematic and simplistic. Space limitations preclude a more thorough analysis; we plan to publish this material separately. We feel, however, that it is crucial to recognize that critical stages in the marriage are intimately related to critical stages in the individual life cycle. Issues that appear to be either purely individual or purely dyadic are often actually the result of a complicated interaction between marital and individual crisis points (especially at ages 30 and 40).

The three dimensions of potential conflict chosen were described in the section on Marital Psychodynamics. Al-

TABLE 1
Individual and Marital Stages of Development

Item	Stage 1 (18–21 years)	Stage 2 (22–28 years)	Stage 3 (29–31 years)	Stage 4 (32–39 years)	Stage 5 (40–42 years)	Stage 6 (43–59 years)	Stage 7 (60 years and over)
Individual stage*	Pulling up roots	Provisional adulthood	Transition at age 30	Settling down	Mid-life transition	Middle adulthood	Older age
Individual task	Developing autonomy	Developing intimacy and occupational identification; "getting into the adult world"	Deciding about commitment to work and marriage	Deepening commitments; pursuing more long-range goals	Searching for "fit" between aspirations and environment	Restabilizing and reordering priorities	Dealing effectively with aging, illness, and death while retaining zest for life
Marital task	Shift from family of origin to new commitment	Provisional marital commitment	Commitment crisis; restlessness	Productivity: children, work, friends, and marriage	Summing up: success and failure are evaluated and future goals sought	Resolving conflicts and stabilizing the marriage for the long haul	Supporting and enhancing each other's struggle for productivity and fulfillment in face of the threats of aging
Marital conflict	Original family ties conflict with adaptation	Uncertainty about choice of marital partner; stress over parenthood	Doubts about choice come into sharp conflict; rates of growth may diverge if spouse has not successfully negotiated stage 2 because of parental obligations	Husband and wife have different and conflicting ways of achieving productivity	Husband and wife perceive "success" differently; conflict between individual success and remaining in the marriage	Conflicting rates and directions of emotional growth; concerns about losing youthfulness may lead to depression and/or acting out	Conflicts are generated by rekindled fears of desertion, loneliness, and sexual failure
Intimacy	Fragile intimacy	Deepening but ambivalent intimacy	Increasing distance while partners make up their minds about each other	Marked increase in intimacy in "good" marriages; gradual distancing in "bad" marriages	Tenuous intimacy as fantasies about others increase	Intimacy is threatened by aging and by boredom vis-à-vis a secure and stable relationship; departure of children may increase or decrease intimacy	Struggle to maintain intimacy in the face of eventual separation; in most marriages this dimension achieves a stable plateau
Power	Testing of power	Establishment of patterns of conflict resolution	Sharp vying for power and dominance	Establishment of definite patterns of decision making and dominance	Power in outside world is tested vis-à-vis power in the marriage	Conflicts often increase when children leave, and security appears threatened	Survival fears stir up needs for control and dominance
Marital boundaries	Conflicts over in-laws	Friends and potential lovers; work versus family	Temporary disruptions including extramarital sex or reactive "fortress building"	Nuclear family closes boundaries	Disruption due to reevaluation; drive versus restabilization	Boundaries are usually fixed except in crises such as illness, death, job change, and sudden shift in role relationships	Loss of family and friends leads to closing in of boundaries; physical environment is crucial in maintaining ties with the outside world

*From Levinson and associates (45).

though the chart is primarily drawn to describe people who marry in their 20s, it describes to some extent the stages that all married people go through.

SYSTEMS OF MARITAL CLASSIFICATION AND DIAGNOSIS

Marital therapists do not yet have a systematic and formally agreed-upon classification of marriage relationships. No one has yet formulated a diagnostic scheme covering all measures. A review of the current systems of classification, however, permits us to look at a number of ways of considering and examining the marital pair. Three of the following classifications are based on the critical dimensions described earlier in this paper, namely, power, intimacy, and marital boundary setting. The fourth classification is based on personality styles familiar to psychiatrists.

Classification 1: Based on Rules for Defining Power

This classification has been proposed by Lederer and Jackson (22).

1. *The symmetrical relationship.* This is a relationship between two people with the same types of behavior; both are expected to give and both to receive; both give orders and both take them. This type of relationship minimizes differences between the two people. Partners are seen as having essentially not only equal but similar role definitions and thus they tend to mirror each other's behavior. Problems tend to stem from competition.

2. *The complementary relationship.* Two people exchange different types of behavior. In marriage this type of relationship is most often described as traditional. One member is seen as "one-up" and one member as "one-down," e.g., helper and helpee. This type of relationship maximizes differences, and each member exchanges dissimilar but need-fulfilling behavior evoked by the other. It tends to be less competitive than other types of relationships and is often highly workable, especially when the "helpee" has some areas to be in charge of. It angers many people because of the implication that the "one-down" person is bad and somewhat inferior.

3. *The parallel relationship.* The spouses alternate between symmetrical and complementary relationships in response to the changing situations. They may be supportive and competitive without fear. According to Lederer and Jackson (22), this is "the most desirable relationship for our egalitarian culture."

Classification 2: By Parental Stage

This classification is a dimension of inclusion-exclusion, or boundary setting, best described by Pollak (51).

In today's nuclear family, the inclusion of children tends to produce the principal disruption to the marital dyad. There is, of course, no question that other groups such as relatives and friends infringe on the couple, but not with such force as children do. The period of child raising tends to be crucial in terms of difficulties for the dyad. Pollak's classification includes the following stages: 1) before child rearing, 2) early child rearing, 3) latency and adolescent children, and 4) after the children leave (the "empty nest").

Classification 3: By Level of Intimacy

This often-quoted system was proposed by Cuber and Harroff (52).

1. *The conflict-habituated marriage.* This marriage is characterized by severe controls, tension, and conflict. Unpleasant as the relationship is, the partners are held together by a fear of aloneness and by the pseudomastery of controlling while angering their partner.

2. *The devitalized marriage.* This marriage is characterized by infrequent expressions of dissatisfaction, probably because of separate activities and interests. This type of interaction is characterized by numbness and apathy and is overtly conflict free but devoid of zest. There is an occasional sharing of companionship, but otherwise the relationship is held together principally by legal and moral bonds and children.

3. *The passive-congenial marriage.* This marriage is "pleasant" and feels comfortably adequate to both partners. There is a sharing of interests but a somewhat uninvolved type of interaction. The principal social supports come from outside the marriage, and interests are with other people. The partners tend to feel that "everyone's marriage is like that," and they derive some genuine feeling of support from the structure of the relationship.

4. *The vital relationship.* This relationship is exciting and rewarding and is highly important to both partners in at least one area, such as child rearing or work. The partners work together in an enthusiastic manner. The individual partner is seen as indispensable to the pleasure of the activity. This marriage can contain some overt conflict, but it is basically a crucial, emotionally rewarding tie as well as a stabilizing force.

5. *The total marriage.* In terms of level of involvement, this type of marriage is similar to the vital marriage except that it is more multifaceted. All reinforcing activities are shared, and the partner is seen as indispensable, whatever the activity. This type of relationship is rare but possible; however, it is particularly precarious because of its multifaceted nature, which can lead to power conflicts.

Classification 4: By Personality Style and Psychiatric Terminology

Several groups have independently proposed this system (9, pp. 303–312; 53). For another variant at a psychodynamic level of interaction, see Mittelmann's work (54); for a general discussion refer to Dicks and Stevens' work (14, pp. 139–154).

1. *The obsessive-compulsive husband and the hysterical wife.* This dyad has also been described as a conflict between the detached husband and the demanding wife, or the " 'cold-sick' man and the love-sick woman." Basically, this pattern involves a somewhat dependent, obsessive man who has particular difficulty in expressing his feelings and who is often seen as the strong, silent

type. This type of man, who is overly concerned with "doing the right thing," often picks a woman who is the stereotype of femininity in our culture. She appears to be passive and somewhat seductive and has a marked tendency toward dramatic self-presentation—in psychiatric terminology, a hysteric. At first she brings great excitement into her husband's life because she expresses and evokes in him feelings that he has never felt before. The release of his feelings excites him, and this enhances his pleasurable appreciation of her. Taking care of her adds to his feelings of importance. On her part, the wife is looking for a good parent, someone who will give her a sense of stability and security.

If the couple begins to experience stress after the period of romance is over, the husband will regard his wife's more intuitive emotional nature and her analogical form of thinking as highly unpleasant and disorganized, and his wife will find his reactive emotional distance highly unpleasant. As she increases her nagging demands and he increases his detachment, each blames the other, whereas it is the transactional system that is really at fault. The relationship tends to be a parent-child interaction and may degenerate from the good parent with the good child to the distant parent with an angry child. Of the three major dimensions of marital interaction, conflicts over intimacy become the central focus.

2. *The passive-dependent husband and the dominant wife.* In these relationships the husband is originally attracted to a self-reliant woman in order to incorporate her strength. Because of his lack of self-assertion he feels inadequate; in addition, he may be alcoholic or obese. He handles his doubts about his masculinity by choosing a woman who will take care of him. He usually picks a woman who has severe conflicts over her feminine role and is highly uncomfortable in a dependent position and therefore chooses a man whom she can control. If this relationship becomes conflict laden, it will be due to the husband's increasing passive-aggressive behavior and depression, a reaction to the wife's attempts at overcontrol. Her inability to control and dominate him and the frustration of her own unconscious dependency needs may lead her to become angry and hostile. Power is the central theme in this transactional system.

3. *The paranoid husband and the depression-prone wife.* This relationship often has significant sadomasochistic elements. The husband, a jealous, suspicious, hostile, and angry man with concerns about his masculinity and a fear of ego disintegration, may pick a woman who has low self-esteem and readily accepts blame. Convinced because of her own poor self-esteem that she cannot do any better, she becomes his wife. Her pathologic low self-esteem can often be traced to rejecting attitudes by excessively critical parents. She may pick a husband who is a psychological replica of her more rejecting parent and from him seek the approval that was unobtainable from the idealized and unreachable parent. These marriages are particularly stormy because both partners have inadequate coping and defense mechanisms and vulnerably low self-esteem. Conflicts are almost always multidimensional.

4. *The depression-prone husband and the paranoid wife.* This relationship is the reverse of type 3. A woman who is suspicious and jealous marries a man who tends to be depressed and distraught. In addition to the masochistic elements in the husband's personality that permit the continuation of the painful relationship, the wife's suspicious and hostile nature gives the man an excuse for not moving out into the outside world, which is seen as threatening. His passive depression allows her to maintain her suspicious and angry behavior without having to cope with a controlling partner. Conflicts often center around the issue of enlarging the marital boundaries to include others.

5. *The oral-dependent relationship.* Both members of the relationship are passive, dependent, immature, and rivalrous. They both have an intense longing for affection and feel that they are giving more than they are getting. Relationships of this type are particularly stormy, although occasionally the partners may be able to take care of each other. Both exhibit temper tantrums and a desire for childish gratifications. Neither one can exhibit interest in the well-being of the other. In this type of relationship, conflicts may center around any of the major themes of marital interaction.

6. *The neurotic wife and the omnipotent husband.* In this relationship the woman is helpless and chronically ill and expects her mate to be omnipotent and relieve her suffering. She expresses unconscious resentment through depression and an exacerbation of symptoms. The husband stays in the marriage because of 1) his desire to help, and 2) his extreme sense of inadequacy. He is strengthened by the idea of helping a person who is weaker than he is, but his continual failure at this results in a loss of confidence. Power is the primary area of conflict.

Comment

It is important to recognize that these marital styles do not always result in severe conflict and divorce. These couples find each other because of some kind of neurotic balance, and if the couple is moderately flexible and has recourse at times to other patterns of behavior, the marriage can go rather well. This is particularly true of the obsessive-compulsive husband and the hysterical wife when the husband is able to accept his wife's rather charming personality and live with her disorganization. Problems arise only when the cost of keeping the system going is too high (for example, when one spouse's depression results in hospitalization and in the reactive wish of the partner to get out of the relationship); when one spouse changes, thereby upsetting the system; or when one partner is not willing to live by the "rules," although the two had married in the expectation that they would.

METHODS OF THERAPY

Types of Marital Therapy

Almost all marital therapies can be placed into the following six categories: individual, collaborative, concurrent, conjoint, combined, and group therapy.

Individual marital therapy. Only one of the two partners is in treatment. This therapy differs from individual psychotherapy in that the focus is on the marriage relationship, even though the format is similar to that used in individual psychotherapy. Individual marital psychotherapy may be psychoanalytically, behaviorally, or interpersonally oriented. Common to all of these approaches is the therapist's attempt to get the patient to make modifications in his or her behavior in the dyadic relationship and to react appropriately to changes in the partner. A second but usually subsidiary goal is to enable the patient to more adequately cope with the problems encountered in the marriage.

Collaborative marital therapy. Both spouses are seen individually by different therapists who meet regularly to exchange their impressions and treatment plans (55). The usefulness of this technique is limited by the difficulties in arranging for frequent meetings of busy therapists and the additional costs to the patients (who have to pay for the time spent in collaboration), as well as by the greater advantages of conjoint marital therapy. It is still of some value, however, particularly in specialized marital therapy clinics where partners who refuse to work together are seen separately. It is most useful in the treatment of couples in the process of separation or divorce, when the spouses' mutual hostility might be increased rather than diminished during conjoint sessions.

Concurrent marital therapy. Both spouses are seen individually by the same therapist (56). In the history of marriage counseling, this was the most frequently used technique until the mid-1960s, when conjoint therapy became the vogue. The concurrent psychoanalysis of a marital pair was pioneered in the late 1940s by Mittelmann (57), who braved the scorn of his analytic colleagues who were unalterably opposed to even a single interview of a family member.

One of the obvious advantages of this type of therapy lies in the screening of perceptual distortions. It is easier for just one therapist to sift out the distortions, and this technique avoids the possibility of each therapist identifying with his own patient and the consequent additional distortions this may create. If the therapist wishes to develop and make use of a transference neurosis, this is a far more effective technique than conjoint marital therapy, in which transference elements tend to be more muted. Concurrent marital therapy is also used effectively in cases where one partner markedly dominates the other, thus preventing the partner from having equal time or an equal share of the therapist's attention. Problems include the re-creation of the triangular sibling rivalry situation, issues of privacy and privileged communication, and lack of opportunity to observe the dyadic function.

Conjoint and combined marital therapy. In conjoint marital therapy the couple is seen together most of the time by one or more therapists (58–61). This has become the dominant mode of marital therapy; approximately 80 percent of all marital therapy is conducted by the conjoint method. If the partners are seen together it is difficult for one partner to assign the blame and to continue to scapegoat the other, making that partner the "sick one." With both partners present, the focus is inevitably on the relationship. One problem in conjoint marital therapy is that there is no opportunity for private exploration, and since in many marriages there are some kinds of private information that the partners will never reveal, the therapy remains at the behavioral level.

In combined marital therapy there is a combination of concurrent and conjoint marital therapy. Concurrent therapy may be augmented by seeing the couple conjointly on a regular or a sporadic basis, depending on the need. This facilitates communication and the feedback of perceptions and feelings, thus enabling the therapist to reduce perceptual distortion and to increase effective communication. Most psychiatrists use the combined method because it provides maximum information about interpersonal behavior and intrapsychic feelings and attitudes. The problem with this type of therapy is that occasionally the focus of treatment is obscured as the therapist tries to shift from the needs of each individual to the transactional aspects of the marriage.

With both combined and conjoint marital therapy, feelings, attitudes, and behavior are displayed in the here and now, thus permitting a more thorough appraisal and evaluation by the therapist. One does not have to wait for feedback; it occurs, even if not immediately, within the session. The data then become more objective because they can be witnessed directly, without the extrapolation required in the historical analysis of the relationship. Ventilation of feelings with catharsis is inevitable. It is difficult for either partner to maintain emotional detachment for very long, since confrontation by the partner or the therapist undermines this defense. Patterns of communication are directly observable and modifiable. Communication skills can be taught directly, and much of marital therapy is directed toward this goal.

Behavior therapy. In addition to the use of insight, the therapist may employ techniques of behavioral therapy (operant conditioning, contingency reinforcement, cognitive restructuring, etc.) that are aimed at reinforcing suitable behaviors. The partner can be used as a cotherapist in these behavioral modifications. (Charting behavioral responses and noting their changes over time is an aid in these efforts.) When persuasion is used directly or indirectly, the partner can also be a cotherapist. An additional advantage is that the partners may engage in behavioral rehearsals of new "tasks." They can practice their new "strokes" of behavioral technique in the therapist's office before trying them out at home. A frequent technique used to advantage in this regard is role playing, or reverse role playing, in which the partner either plays himself in a hypothetical situation or takes on the role of his partner.

Many therapists, notably Hollender (62), have voiced concern about moving back and forth between a marital- and individual-oriented therapy method. Their questions center on the inadvisability of changing the therapeutic focus, the possibility of confusing goals, and a "scattergun" approach. We have found that both individual therapy concurrent with marital therapy and the therapist's

willingness to shift focus between individual and dyadic therapy as the treatment evolves are valid methods of procedure. As long as the change in method of therapy is discussed with the patients and agreed upon beforehand, the patients generally respond well and with a minimum of confusion. There is precedent for this approach in other "combination therapies" that are frequently used today, such as group plus individual treatment and insight-oriented therapy plus medication.

Other Therapeutic Methods

In recent years specialized techniques have been developed using videotaped playback as an important aid to marital behavioral changes (63–65). Increased use is also being made of group therapy for marital partners (66–70). There are some who claim that group therapy is the treatment of choice for couples. This is particularly true of couples who are attempting to manage transactional crises that require role modifications for effecting appropriate adaptation to changing life circumstances. It should be remembered that even when the therapist is working with only one dyad, it is a form of group therapy. As Dicks and Stevens (14, pp. 139–154) stated, "It is group psychology for the smallest numerical group."

The Place of the New Sex Therapy in Marital Therapy

The behavioral techniques for the treatment of sexual dysfunction, first described by Masters and Johnson (71) and modified by Kaplan (72), have given major impetus to the treatment of sexual dysfunction in the marital dyad. The high rate of success of conjoint behavioral techniques indicates that although individual therapy methods for curing sexual dysfunction are sometimes necessary, neglecting couples' interactional problems means the loss of crucial vectors in undoing maladaptive mechanisms that have either initiated or maintained the dysfunction.

However, those beginning to employ behavioral techniques tend to use them mechanically in a nondiscriminatory fashion without regard for the basic principles of marital therapy. In fact, these behavioral techniques—operant conditioning, contractual contingencies, and task assignments—should be regarded as an elegant form of desensitization and behavioral modification (73), with their success subject to all of the vicissitudes of the marital system. The successful use of these techniques depends on a basic understanding of the couple's dynamics and resistances. Sex therapy cannot be conducted separately from an examination of the couple's communication pattern and their wishes for and fears of intimacy and power. The best available description of how these techniques can be integrated with marital and individual psychodynamics can be found in Kaplan's *The New Sex Therapy* (72).

Dual Sex Therapy

Ever since Masters and Johnson (71) described the advantages of using two sex therapists in the treatment of sexual problems, psychiatrists have shown a great deal of interest in the possible uses of this approach. Masters and Johnson stressed the ability of the dual sex team to decrease opposite-sex transference manifestations, as well as the use of patient support by the same-sex cotherapist. Other researchers, including Bruni (74), have found that the dual sex cotherapist's interventions—support; interpretation of feelings; and explanations of transference, behavior, marital interactions, confrontations, etc.—can be carried out without the sex-linked limitations imposed by the Masters and Johnson plan. The modeling of behavior or suggestion of a new perspective can be done by the therapist of the same or opposite sex.

Many of the advantages of the dual sex team in sex therapy are present in the treatment of couples who have other types of marital dysfunction. This approach does not have to be restricted to the treatment of sexual disorders or dysfunctions. One therapist can aid the other by augmenting interventions, adding additional insights or emotional supports, and correcting "off-target" interventions. The opportunity to check one's perceptions and understanding with the cotherapist is as important here as it is in group therapy.

As in group therapy, effective teamwork depends on the capacity to pick up cues from the other therapist as well as from the patients and to interact with the cotherapist to strengthen, modify, or redirect responses of the therapist-partner. Confrontations often have much more impact in this method of treatment than in the usual form of treatment with one therapist. Cotherapists often describe the "fun," even the exhilaration, of a successful session in which female and male therapists have worked together effectively. The special elements of treatment when the dual sex team is a husband-and-wife pair have been described by Bellville, Raths, and Bellville (75).

The main disadvantage of using cotherapists is the increased cost due to the large amount of therapist time involved in treatment and its coordination. In addition to the cost of two therapists, which has to be passed on to the patients, ineffective teamwork due to poor communication, competition, countertransference reactions, etc., may more than outweigh the advantages of the dual sex therapy model.

DIVORCE AND THE FUTURE OF MARRIAGE

American psychiatrists and marriage counselors have become increasingly involved in two complex and related social-psychological phenomena: the rising divorce rate and the search for alternative lifestyles. The central philosophical question surrounding the controversy has been whether these phenomena stem from new sets of social and marital stresses common to the late 20th century or whether they are simply new solutions to old problems (76). At any rate, therapists are increasingly being asked to take sides regarding the appropriateness of divorce or new lifestyles, while continuing to treat the battle scarred (77).

In our opinion, both the rising divorce and remarriage rates and the increase in new marriage styles and fashions ("swinging," open contracts, group marriage) are social

rather than psychopathological phenomena and are principally a reaction to the increased expectations and demands for happiness, autonomy, and experience collection common to the 1960s. In fact, it may turn out that these are essentially fads and are already past their peak. Some researchers (78, 79), however, see the rise in open contracts and serial monogamy as essentially normal and potentially healthy responses to longer lives and more urban lifestyles. They predict an increase in the quantity and quality of such new experiments.

We still are faced, however, with numerous patients entering our offices, most of whom are alone, uncertain and anxious about whether to divorce, depressed after a recent divorce, or debating the need for "more experience of life." Their complaints may be voiced in terms of blaming their spouses or their need to reevaluate their lives and find new stimulation.

Aids to Therapy

We have found the following concepts particularly helpful as an aid to therapy.

1. We have learned that almost never, under any circumstances, can a therapist accurately predict the personality or behavior of the other spouse solely from his partner's report. Reality pressures tend to be either much milder or much more overwhelming when described by the spouse. We have therefore insisted under all possible circumstances that the partner come in for at least a brief meeting.

2. The issue of the therapist's role in decision making is sometimes complicated and delicate. Both in conflict over divorce and over altered lifestyles, the usual method is to help the partners lay out the alternatives and choose among them. On the other hand, when the evidence of permanent dysfunction seems overwhelming, we have occasionally deliberately supported a trial separation. It is notable that although we seldom give advice, it is even more seldom that our patients take and act upon it.

3. When the partners have different commitments to their marriage (and consequently to marital therapy), marital therapy may have to be suspended. If one spouse is only partly committed to the marriage, or if one or both of the spouses want to end the marriage, standard marital counseling is simply not possible. The focus must be on the couple's decision about whether to stay in the marriage. If one member wants to abandon the marriage, we can offer only separation counseling. Some couples, however, will remain indecisive for many months, and the therapist must deal with the problems and the questions created by their indecisiveness.

4. Regardless of how bad the marriage is for both spouses, most divorced single people find that living alone is excruciatingly painful. Many divorced people face a period of depression that lasts from a few months to as long as a year. We must accept the existential fact that for many long-married couples, there simply are no painless decisions. Remaining in the marriage is painful, but living alone is more painful, and other options may well be closed to them.

5. Alternative lifestyles, particularly group marriages, are harder to maintain than monogamous relationships and require more flexibility and maturity than living alone.

6. We have found that in many cases, separating and divorcing partners learn to *handle* their problems better in group therapy than in individual therapy. The focus in the initial postseparation period must be on support and a new lifestyle. Most people are in no shape to really examine the conflicts that brought them to the point of separation. Groups provide much more direct support and, if the group is well led, do not increase the bitterness felt by the separating or divorced person.

Comment

In summary, we feel that alternative living arrangements and serial monogamy will be the continued choice of some people. In general, however, most people in our culture seem to prefer a monogamous lifestyle with some element of long-term security. Marriage as an institution is therefore likely to survive, although it will feature more emphasis on equal rights for women (52), less of a sense of ownership or possession of the spouse, and hence some decrease in sexual jealousy. The human-potential movement and the development of community programs for marital enrichment speak to the need of vast numbers of people to find greater individual fulfillment in the context of a growing, developing, and vital partnership.

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Neuroleptics, Catecholamines, and Psychoses: A Study of Their Interrelations

BY HERMAN M. VAN PRAAG, M.D., PH.D., AND JACOB KORF, PH.D.

The authors examined central catecholamine metabolism in various symptomatological psychotic disorders and the relationship between the biochemical and therapeutic action profiles of neuroleptics. Haloperidol and (to a lesser extent) chlorpromazine increase the dopamine (DA) turnover in the central nervous system, but the noradrenaline metabolism is not demonstrably influenced; oxypertine has the reverse effect. The authors question whether disorders of DA metabolism underlie or result from disorders of motor activity, postulating that the hyperdopaminergic activity observable in psychoses is dependent on motor hyperactivity rather than on "true" psychotic symptoms such as delusions and hallucinations.

IN SEVERAL ANIMAL species neuroleptics increase the turnover rate of dopamine (DA) and noradrenaline (NA) in the brain (1, 2). There are indications that this effect is secondary to a block of DA and NA receptors (3). It may be that the increased turnover can be interpreted as a compensatory phenomenon aimed at breaking the block.

With regard to the question whether central DA turnover in man is also enhanced by neuroleptics, the probenecid technique can be useful (4–6). Probenecid inhibits the transport of homovanillic acid (HVA), the principal metabolite of DA, from the cerebrospinal fluid (CSF) to the bloodstream but does not influence HVA synthesis. This means that the amount of HVA which accumulates in the CSF is an index of the amount of DA metabolized in the central nervous system. Under steady state conditions, the rate of HVA synthesis equals the rate of DA degradation. A strong HVA response in the CSF following probenecid administration therefore indicates a high production of this metabolite and consequently a high turnover of DA. Inversely, accumulation of a small amount of HVA warrants the suspicion that HVA production is low and that therefore the DA turnover is low.

When Bowers (7) treated 12 patients who had LSD psychoses with various phenothiazines, he found a stronger HVA response to probenecid than before medication. The interval between the two probenecid tests varied from two weeks to three months. The neuroleptic dosage was not specified, and the increase averaged only 25 percent. This may have been related to the fact that the majority of the patients received an anticholinergic antiparkinsonian drug; in animals these agents suppress the increase in central HVA concentration produced by neuroleptics (8). In 6 patients in different neurological categories, Chase (9) found that haloperidol (Serenase) caused a significant increase in probenecid-induced HVA accumulation. As pointed out, the increase in HVA accumulation can be regarded as expressive of an increased DA turnover.

With regard to humans, we know nothing about the influence of neuroleptics on the central NA metabolism, about a differential influence of different neuroleptics on DA and NA metabolism, or about the significance of the dosage factor.

Assuming that relationships exist between catecholamine (CA) receptor block and the therapeutic action of neuroleptics—and there are some indirect arguments to support this assumption (3)—the question arises whether the central CA metabolism may be disturbed in psychotic patients and specifically whether there are signs of catecholaminergic hyperactivity. We know of one relevant probenecid study, which showed that the HVA response was more pronounced in Schneider-negative patients than in Schneider-positive patients and depressive patients (10). Otherwise there are two indirect arguments suggestive of a relationship between DA metabolism and psychosis. Amphetamines and L-dopa can provoke psychotic symptoms in nonpsychotic individuals and aggravate these symptoms in psychotic individuals (11–13). By different mechanisms of action, these two compounds increase the intracerebral amount of DA available at the receptors. There are no data at all on a possible relationship between NA metabolism and psychosis.

In this study we have raised two questions: 1) What is the effect of various types of neuroleptics in various doses on human central CA metabolism? 2) Do disorders of central CA metabolism occur in psychotic patients?

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METHOD

Patients

This study encompassed 33 patients consecutively hospitalized in the research unit of the Department of Biological Psychiatry for acute psychotic disorders. According to the independent views of the physician in charge as well as the psychiatrist supervisor, all patients showed delusions and/or hallucinations. Delusion was defined as an idea whose content is probably at variance with reality but nevertheless not susceptible to correction. An experience was regarded as a hallucination 1) if, according to the patient's own words, it occurred in a sensory modality (auditory, visual, gustatory, olfactory, tactile, kinesthetic, or combinations of these) and 2) if current objective stimuli were, in the opinion of the interviewer, either totally absent or grossly inadequate to account for the experience (14). Patients suffering from melancholia, i.e., deep endogenous depression with delusions of guilt, sin, and/or poverty, were not included in this study.

The group consisted of 19 women aged 19 to 58 years (mean age=37) and 14 men aged 18 to 64 years (mean age=40). Table 1 presents a general survey of the predominant symptomatology and the etiological factors considered most important in the given case. Nine women and 8 men had been admitted with a relapse; 4 women and 5 men had a history of three or more hospitalizations because of psychosis.

TABLE 1
Etiology and Symptomatology for 33 Patients Treated with Neuroleptics

Item	Chlorpromazine (N=12)	Haloperidol (N=10)	Oxypertine (N=11)
Schizophrenic process			
Paranoia	2	0	0
Delusions*	1	1	1
Hallucinations	0	0	1
Motility disorders	1	2	0
Cerebral process			
Paranoia	0	0	0
Delusions	0	0	0
Hallucinations	1	0	0
Motility disorders	0	1	0
Extracerebral process			
Paranoia	1	0	0
Delusions*	1	0	0
Hallucinations	0	0	0
Motility disorders	0	1	0
Psychogenic factors**			
Paranoia	1	0	3
Delusions*	3	0	1
Hallucinations	1	1	3
Motility disorders	0	4	2

*Excluding paranoia.
**Including sociogenic and neurotic factors.

Medication

All psychopharmacotherapy was discontinued upon the patients' admission. Neuroleptic medication was started not earlier than 5 and not later than 10 days after admission, unless the psychosis had faded without medication, as it sporadically had. Because of high levels of agitation in 11 patients, they could not be maintained without medication until neuroleptic therapy began. During the interval these patients were sedated with three to four daily doses of a standard powder containing 100 mg of amobarbital (Amytal), 100 mg of bromisovalum (Bromural), and 100 mg of methylphenobarbital (Prominal). The concentration of monoamine (MA) metabolites in the CSF was not systematically influenced by this medication. The following neuroleptics were given:

1. Chlorpromazine (Largactil, manufactured in France) in a daily dose of 150 to 225 mg (N=6) or 300 to 450 mg (N=6). This neuroleptic blocks both DA and NA receptors in the brain in test animals (15, 16).

2. Haloperidol (Serenase, manufactured in Belgium) in a daily dose of 3 to 4.5 mg (N=5) or 9 to 12 mg (N=5). This neuroleptic more or less selectively blocks DA receptors (15, 16).

3. Oxypertine (Opertil) in a daily dose of 50 to 100 mg (N=5) or 150 to 200 mg (N=6). This neuroleptic differs in type from the previous two neuroleptics. It is not a receptor blocker but a compound that, like reserpine, depletes the CA stores. However, it is more selective than reserpine in that, within a certain dosage range, it has a predilection for NA stores and exerts little influence on the DA and serotonin (5-hydroxytryptamine [5-HT]) stores (17). We used this agent because a drug capable of blocking central NA receptors more or less selectively was not available at the time.

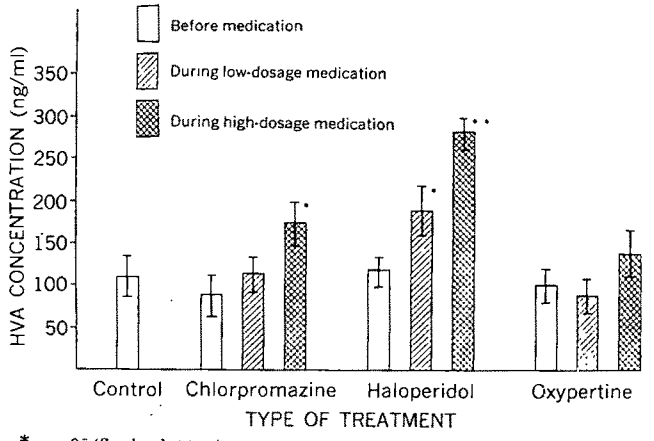
Unless there was severe agitation, patients were placed at random in either group 1 or group 2 within 5 to 10 days after admission. Earlier findings had indicated that oxypertine can exert a stimulating influence, thus aggravating agitation. For this reason seriously agitated patients were treated with haloperidol.

CA Metabolism

The DA metabolism was studied in all patients, always with the aid of the probenecid technique (4–6). The probenecid test was carried out twice: once after an interval of 5 to 10 days without medication or without neuroleptics, and once after two weeks' medication with one of the previously mentioned neuroleptics. The load used was 5 g of probenecid in 5 hours and the first 1-g dose was given by intravenous drip. The procedure of the probenecid test has been described elsewhere (18). Determinations in the CSF included, in addition to HVA (19), 5-hydroxyindoleacetic acid (5-HIAA, the principal degradation product of 5-HT [20]) and probenecid (21).

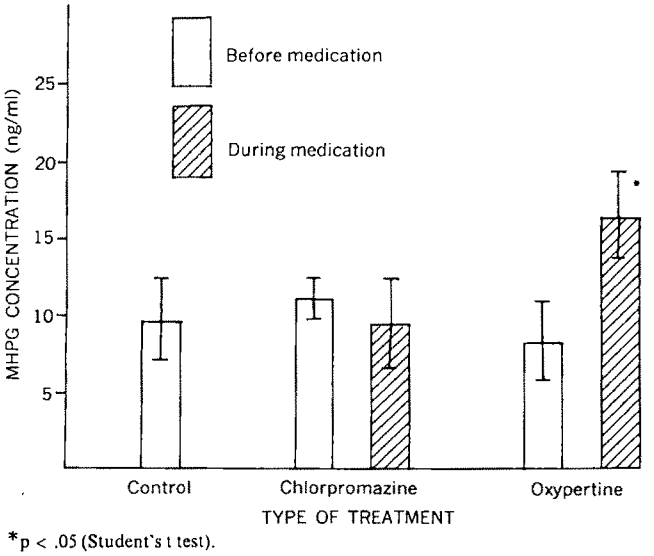
In 10 patients (5 of whom were treated with large doses of chlorpromazine and 5 with large doses of oxypertine) the central NA metabolism was evaluated on the basis of the baseline concentration of 3-methoxy-4-hydroxyphenyl glycol (MHPG) in the CSF, measured before medication and at the end of the second week of medication. MHPG is the principal metabolite of NA in the brain. Its transport from the brain is not influenced by probenecid, and therefore the probenecid test cannot be used for a study of the central NA metabolism (22).

FIGURE 1
Increase in HVA Accumulation (± SEM) in the CSF in Response to Probenecid During Treatment with Neuroleptics in Various Doses



*p < .05 (Student's t test).
**p < .01 (Student's t test).

FIGURE 2
MHPG Concentration (± SEM) in the CSF Before and During Treatment with Chlorpromazine and Oxypertine



*p < .05 (Student's t test).

(A number of MHPG assays were done for us by Dr. S. Wilk using a method of his own design [23].)

Scoring

Two rating scales were used: 1) a modified Wing scale (24), a three-point rating scale aimed at visually observable variables of behavior that has a high interrater reliability (25), which was scored by the department research nurses, and 2) a three-point rating scale of our own design in which scoring requires verbal communication with the patient by the attending physician. Both scales were scored before medication and twice weekly during medication, always on the same day of the week and at the same hour.

FIGURE 3
5-HIAA Concentration (± SEM) in the CSF After Probenecid Administration Before and During Treatment with Neuroleptics in Various Doses

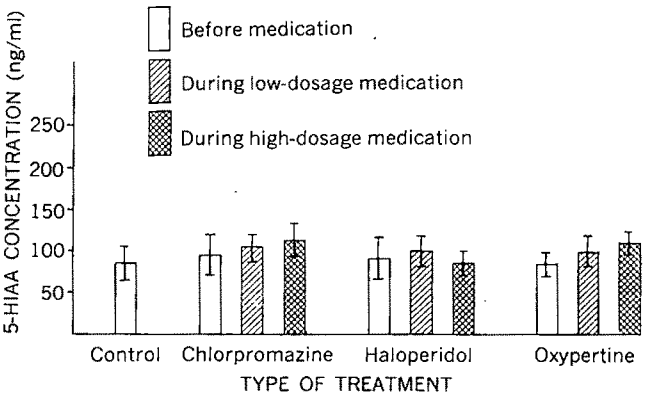
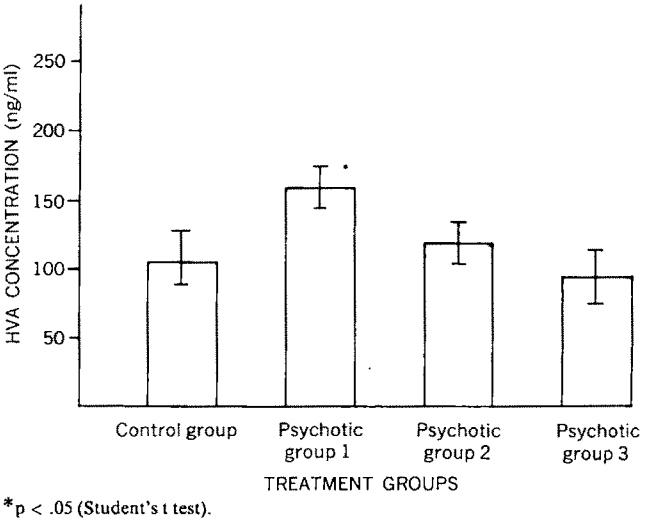


FIGURE 4
HVA Accumulation (± SEM) in the CSF After Probenecid Administration in Psychotic Patients with Manifest Delusions and/or Hallucinations



*p < .05 (Student's t test).

Statistical Analysis

Statistical comparisons were done using Student's t test for grouped or paired data.

RESULTS

Haloperidol caused a dose-dependent increase in HVA accumulation after probenecid. In large doses it caused triplication of the response; in small doses it caused duplication (figure 1). The effect of chlorpromazine was less pronounced but likewise dose-dependent. A maximum dose doubled the HVA response (figure 1). MHPG baseline values were available for five patients in this group and showed no increase during medication (figure 2). Oxypertine caused no increase in HVA response (figure 1). MHPG values were available on five patients given

large doses. In all of these patients the concentration had increased during medication (figure 2). None of the neuroleptics caused an increase in 5-HIAA accumulation (figure 3).

On the whole, the HVA response in the CSF after probenecid in the psychosis group was slightly but not significantly higher than in the control group. The psychosis group was divided into three categories as shown in figure 4: group 1, patients who attained the highest score on the motor agitation item—all scored maximally on the anxiety item as well (N=10); group 2, patients who scored maximally on the anxiety item but showed absence of or no severe motor agitation (N=8); and group 3, patients who, like all the others, showed delusions or hallucinations but no serious degree of motor agitation or anxiety (N=15). The HVA response was significantly increased in group 1 but was not significantly higher than normal in the other two categories. In all patients the CSF probenecid concentration varied within normal limits (10.45±4.79 μg/ml). The available number of MHPG values was too small for systematic differences to be established with certainty.

DISCUSSION

Neuroleptics comprise a group of compounds of disparate chemical structure, such as phenothiazines, butyrophenones, and diphenylbutylamines. Nevertheless, these compounds have two characteristics in common. In psychopathological terms they exert a beneficial influence on motor agitation and on psychotic disturbances in thought and experience. In biochemical terms they increase the intracerebral turnover of DA and NA—a phenomenon that is probably secondary to DA- and NA-receptor block. A number of closely interrelated questions logically arise from these findings.

1. Are there indications that neuroleptics also increase the central CA turnover in humans?
2. Is the central CA metabolism disturbed in psychoses? Specifically, can there be dopaminergic or noradrenergic hyperactivity?
3. Is there a relation between the ratio of DA receptor to NA receptor-blocking activity and the clinical action profile of a neuroleptic?

These questions provided us with a research strategy we used in a biological study of psychotic disorders (3). In the present study we are concerned with the first two questions.

We studied chlorpromazine, haloperidol (prototypes of phenothiazines and butyrophenones, respectively), and oxypertine. This choice was made on the basis of biochemical considerations. In test animals, chlorpromazine blocks DA as well as NA receptors. Haloperidol is a fairly selective DA-receptor blocker (15, 16). Oxypertine is not a CA-receptor blocker but an MA depleter with a predilection for NA stores, at least within a certain dosage range (17). A relatively selective blocker of central NA receptors was not available at the time.

In human CSF, haloperidol and, to a lesser extent, chlorpromazine caused a dose-dependent increase in the HVA response after probenecid administration. This indicates that in man as well as in test animals, these neuroleptics increase the DA turnover in the CNS. The MHPG baseline values (MHPG transport from the CNS is not influenced by probenecid) did not increase during medication. However, it would be premature to conclude from these findings that chlorpromazine exerts little influence on human NA metabolism. CSF baseline values of an MA metabolite are a much cruder and less reliable index of central MA metabolism than postprobenecid values.

Neither chlorpromazine nor haloperidol influenced the 5-HIAA accumulation after probenecid administration; this corresponds to the observation in test animals that these compounds have no effect on the 5-HT turnover.

Oxypertine caused no change in probenecid-induced HVA and 5-HIAA accumulation, indicating that it exerts little influence on the metabolism of DA and 5-HT. The MHPG concentration, however, increased significantly. This is consistent with the concept of oxypertine as an NA depleter that causes the NA concentration to decrease and the concentration of the NA metabolites to increase. Our results are therefore in agreement with what might be expected on the basis of data from animal experiments.

In the psychosis group, in which all patients showed delusions and/or hallucinations, the HVA response after probenecid administration was slightly but not significantly above the normal. When the group was divided into three categories on the basis of the severity of the symptoms of motor agitation and anxiety, the HVA accumulation in untreated, severely agitated patients proved to be significantly above the normal. An increased HVA response indicated an increased DA turnover in the CNS, and an increased DA turnover can tentatively be related to increased dopaminergic activity.

If this is the case, our observations would suggest that hyperdopaminergic activity occurs in psychoses but that this phenomenon is bound to the state of motor hyperactivity rather than the "true" psychotic symptoms (delusion and hallucination). These findings could be described as a mirror reflection of our earlier observation that the HVA response to probenecid is subnormal in depressive patients with motor retardation, as well as in patients with Parkinson's disease (4, 18). At the time, this prompted us to formulate the hypothesis that DA deficiency depends not so much on one specific extrapyramidal syndrome as on a given motor state (i.e., hypokinesia).

In some forms of extrapyramidally determined hyperactivity, the HVA response was found to be increased (26). This warrants the suspicion that this phenomenon, too, is not nosologically or syndromally specific but symptom specific and bound to certain types of motor hyperactivity. This hypothesis is corroborated by an observation reported by Post and associates (27) that the HVA response increases in test subjects who "simulate" hyperactivity.

Post and Goodwin (28) drew a different conclusion

from their simulation experiment, namely, that the increased DA turnover has no primary etiological significance but is an epiphenomenon, i.e., a phenomenon secondary to the behavior disorder. In our opinion the observation does not warrant this particular conclusion. To answer the question of whether dopaminergic hyperactivity is a primary or a secondary phenomenon in relation to motor hyperactivity, only two types of experiments are suitable for human subjects: 1) experiments to establish whether the biochemical disorder precedes the behavior disorder chronologically and 2) experiments to establish whether selective correction of the biochemical disorder abolishes or at least greatly reduces the behavior disorder. If the biochemical lesion precedes the behavior disorder and/or if elimination of the former leads to disappearance of the latter, then the primary character of the biochemical lesion is plausible.

In depressive patients with a low HVA response, L-dopa (a more or less selective corrector of DA deficiency) proved to stimulate motor activity; this was not the case in depressive patients with a normal HVA response (29). The favorable effect of L-dopa on parkinsonian hypokinesia is well known. It is an argument in favor of an etiological relation between dopaminergic hypoactivity and motor hypoactivity. A comparable experiment with hyperactive patients and a selective DA antagonist, e.g., pimozide (Orap), could supply information on the question whether motor hyperactivity is or is not due to dopaminergic hyperactivity. Such research is now in progress in our department.

Biological depression research shows an unmistakable trend in favor of differentiation of depressive syndromes on the basis of biochemical criteria relating to the MA metabolism. This in turn leads to efforts to evolve drugs that selectively influence a single central MA, in hopes of being able to also selectively correct the behavior disorders with these agents (29). It seems likely that a similar hopeful evolution will also occur in the biological investigation of psychotic disorders.

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A Comparison of Biofeedback-Mediated Relaxation and Group Therapy in the Treatment of Chronic Anxiety

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The authors compared treatment of chronic anxiety with biofeedback-mediated electromyographic (EMG) relaxation to treatment with group psychotherapy in a control group. Feedback patients were given two weeks of EMG relaxation training followed by two weeks of self-practice. Significant decreases were found in the feedback group in electromyogram levels, mood disturbance, trait anxiety, and (to a lesser extent) state anxiety; no such decreases occurred in the control group. The authors suggest that EMG feedback can be an important adjunct therapy for chronic anxiety.

CHRONIC ANXIETY is a primary complaint in many patients with a variety of psychiatric disorders. Conventional therapies have been of limited effectiveness, which points to the need for additional therapeutic options. Biofeedback-mediated electromyographic (EMG) relaxation, an extension of progressive relaxation (1) and autogenic training (2), has been viewed with increasing interest as a possible treatment technique. Although much has been written concerning this technique, there has been a conspicuous lack of studies using control groups or comparison groups given traditional treatment methods.

Recently Raskin and associates (3) suggested that EMG relaxation achieved through biofeedback techniques is a clinically useful strategy for treating some patients with chronic anxiety. As was mentioned in that study, the lack of a comparison group leaves unresolved the question of the contribution of biofeedback-mediated EMG relaxation as compared to other therapies.

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The present study was designed to compare anxiety and mood changes in a group of patients with chronic anxiety who learned EMG relaxation by biofeedback methods with a group receiving a more traditional treatment, group psychotherapy.

PROCEDURE

Thirty patients were selected from the Inpatient Psychiatric Service at the Naval Regional Medical Center, San Diego, Calif., within five to eight days after their admission to inpatient status. Selection criteria consisted of 1) the psychiatrist's judgment that anxiety was a significant factor in the patient's illness, 2) the patient's judgment that anxiety was a major problem, and 3) scores on the State-Trait Anxiety Inventory (STAI) comparable to those reported for anxiety reaction. Patients with physical ailments, less than eighth-grade education, or cognitive or affective impairment sufficient to prevent comprehension of instructions and concentration during treatment were excluded from the study.

The study lasted four weeks. During the week preceding the study, there were two consecutive baseline days on which pretreatment values for resting frontalis EMG, STAI, and Profile of Mood States (POMS) scores were obtained for all patients. Patients were matched in pairs on a combination of resting frontalis EMG level, STAI scores, and the total mood disturbance score from the POMS.

Briefly, the STAI consists of two self-rating scales; the state scale reflects the respondent's feelings at the moment of answering the questionnaire and the trait scale inquires into feelings the respondent identifies as having persisted over a period of time. In the present study, the trait instructions were as follows: "Mark the answer that describes how you have felt on the average since the last time you filled out this questionnaire." The POMS is a self-rating instrument yielding a set of six factor-derived scores based on responses to a list of affective adjectives. The scales can be combined into a single score reflecting overall mood disturbance. The POMS instructions also required that the responses be based on feelings and mood since the patient last completed a POMS form.

Random selection was used to place one patient of each pair in the EMG feedback group; the other patient was placed in the comparison group.

Feedback Group

The EMG training device was the Bioelectric Feedback System Model B-1 (Bio-Feedback Systems, Inc., Boulder, Colo.). This device provides the patient with both auditory and visual information on EMG level for the monitored muscle group. A digital readout provides the experimenter with the integrated EMG level, in microvolts, for each trial (64 seconds in this study).

The feedback group received nine 20-minute EMG feedback training sessions—four during the first week, four during the second week, and one on the first day of the third week. During this same period, the feedback patients also practiced deep muscle relaxation for one-half hour each day using tape-recorded instructions designed to be used with the feedback procedures.[1] Self-practice without the taped instructions continued during the third and fourth weeks of the study.

Comparison Group

Group psychotherapy is a term that is loosely defined and describes more a therapeutic set than a specific treatment (4). The comparison group was given a short-term structured group therapy experience dealing specifically with anxiety. Sixty-minute sessions were held for groups of 4 or 5 patients with a therapist who presented Thematic Apperception Test picture cards to the group for individual and then group discussion. Cards were selected to focus the group's attention as much as possible on a common set of experiences at the outset of each therapeutic session. Patients were instructed each time to discuss anxiety provoking aspects of the pictures. This was followed by group discussion of experienced anxiety, possible methods to cope with anxiety, and intermember support and interaction. The comparison group met four days each week for the duration of the study, for a total of 16 sessions. Although short-term, the therapy was intensive and representative of the group therapies usually offered to hospitalized patients (5).

For the sake of convenience, experimental days will be referred to in terms of the feedback group's schedule. Resting frontalis EMG level and STAI scores were obtained for both feedback and comparison patients on baseline days 1 and 2, feedback day 6, and self-practice days 6 and 14. The POMS was administered on baseline days 1 and 2, feedback days 5, 7, and 9, and self-practice days 6 and 14. All questionnaires were administered immediately before EMG monitoring. Medication records were kept on all patients during the study.

RESULTS

Two patients from the feedback group and 7 from the comparison group failed to complete the first three weeks of the study due to administrative action (discipline, discharge, or transfer) and were therefore not included in the data analysis. At the end of three weeks, there were 13 feedback and 8 comparison patients. Three feedback patients were lost between the third and fourth weeks. Of the 15 feedback and 15 comparison patients who began the study, 10 and 8, respectively, completed the full four weeks. Although the uncontrollable loss of patients resulted in unmatched baseline scores, the differences in baseline scores between the two groups who completed the study were not statistically significant by either paired t tests or sum of ranks tests (all p values were greater than .20). The use of change scores for subsequent between-groups comparisons removed the effect of the unequal baseline scores.

To determine the effect of EMG relaxation training and the comparison procedures on EMG, STAI, and POMS scores, the changes in each score relative to the baseline were tested with t tests for correlated means. One-tailed tests were used because there was an a priori expectation that both EMG feedback and the comparison procedure would be accompanied by either no change or a decrease in EMG level, anxiety, and mood disturbance. The between-groups comparison consisted of testing the change from baseline for the feedback group against the change from baseline for the comparison group. Tests for differences between the two groups were done with t tests for independent means. For EMG levels, one-tailed tests were used because of the expectation from previous studies that feedback would reduce EMG below levels reached without feedback (6). Two-tailed tests were used for anxiety and mood scale comparisons between the two groups since there was no previous evidence to suggest that EMG feedback would be more effective than other methods for reducing anxiety and mood disturbance scores.

Electromyogram Scores

Scores for both baseline and feedback sessions were the mean integrated EMG level, in microvolts, during the last six 64-second trials of a 640-second (10 trials) measurement period. For the baseline measurements, patients were told to become as relaxed as possible, but no feedback was given. In the comparison group, there were no significant changes in EMG level compared to baseline over the course of the study. In the feedback group, EMG was significantly decreased compared to baseline midway through training on feedback day 6 ($t=5.014$, $df=12$, $p<.001$) and after training on both self-practice day 6 ($t=4.617$, $df=12$, $p<.001$) and self-practice day 14 ($t=2.066$, $df=9$, $p<.05$).

Frontalis EMG for the feedback group was significantly lower than for the comparison group on self-practice day 6 ($t=1.811$, $df=16$, $p<.05$). On self-practice day 14 the decrease in EMG was greater for the feedback group, but this difference was not statistically significant. Figure 1 shows these changes expressed as percentage of baseline.

Profile of Mood States Scores

In the comparison group, there were no significant changes from baseline in POMS scores across the study.

[1]Tape-recorded relaxation instructions were provided by Dr. T.H. Budzynski.

FIGURE 1
Comparison of Results of Treatment with EMG Feedback and Group Therapy

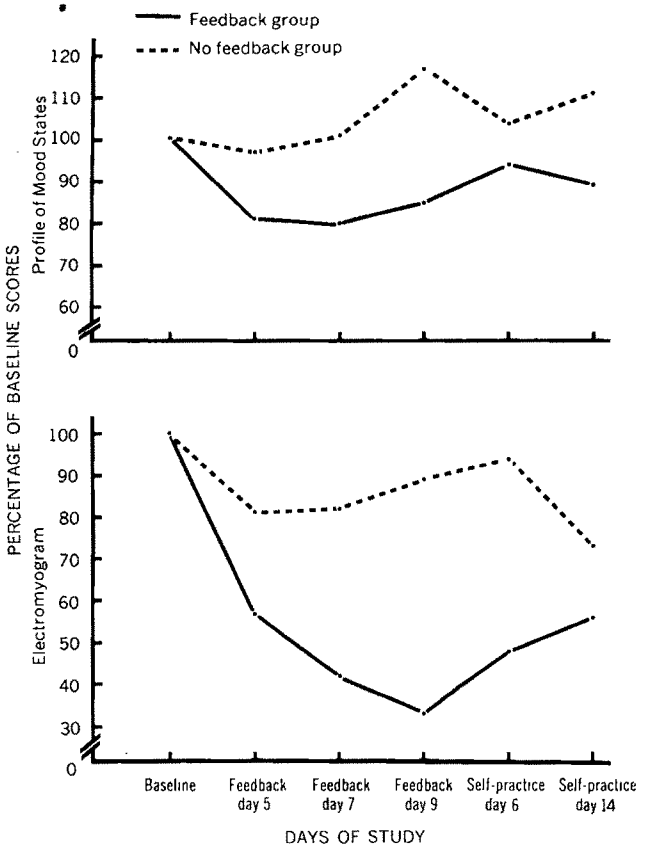


TABLE 1
State and Trait Anxiety Scores Before, During, and After Feedback Training and Group Therapy

	Scores of Feedback Subjects		Scores of Comparison Subjects	
Experimental Day	Mean	SD	Mean	SD
State anxiety				
Baseline	51.33	12.99	40.88	15.49
Feedback day 6	40.58*	11.29	40.63	17.34
Self-practice day 6	43.33	11.03	37.25	14.96
Self-practice day 14	43.83	11.97	41.75	16.50
Trait anxiety				
Baseline	49.83	9.99	43.13	19.22
Feedback day 6	44.66**	9.88	43.38	19.72
Self-practice day 6	46.50	13.22	41.00	17.84
Self-practice day 14	44.50***	12.77	40.63	19.27

*$t=3.597$, $df=12$, $p<.005$.
**$t=3.199$, $df=12$, $p<.005$.
***$t=1.845$, $df=9$, $p<.05$.

(These scores for both groups are illustrated in figure 1.) POMS scores for the feedback group were significantly lower than baseline on feedback day 5 ($t=3.886$, $df=12$, $p<.005$), feedback day 7 ($t=2.804$, $df=12$, $p<.025$), feedback day 9 ($t=2.317$, $df=12$, $p<.025$), and self-practice day 14 ($t=1.871$, $df=9$, $p<.05$). Change from baseline scores for the two groups did not differ significantly from each other on any of these test days.

State-Trait Anxiety Inventory

There were no significant changes in state or trait anxiety scores for the comparison group (see table 1). For the feedback group, state anxiety was significantly lower on feedback day 6 than at baseline ($p<.005$). Both self-practice days 6 and 14 were lower than baseline, but the difference did not reach statistical significance ($.05<p<.10$). For trait anxiety, the feedback group had significantly lower scores compared to baseline on feedback day 6 ($p<.005$) and self-practice day 14 ($p<.05$). Over the course of the study, there were no significant differences between the comparison and feedback groups in change from baseline in state or trait anxiety.

Changes in EMG, Anxiety, and Mood

To examine the relation of change in EMG to change in anxiety and mood disturbance, correlation coefficients were computed between change in test score and change in EMG for baseline minus feedback day 6 (feedback day 5 for the POMS), baseline minus self-practice day 6, and baseline minus self-practice day 14. For the comparison group, there were no significant correlations of EMG change with change in anxiety or mood disturbance scores. For the feedback group, change in mood disturbance was significantly correlated with change in EMG for baseline minus feedback day 5 ($r=.60$, $df=12$, $p<.05$). Change in state anxiety was significantly correlated with change in EMG for baseline minus feedback day 6 ($r=.61$, $df=12$, $p<.025$) and for baseline minus self-practice day 6 ($r=.58$, $df=12$, $p<.05$).

Overall Patient Improvement

Patient improvement was arbitrarily defined as a 20 percent or greater decrease in at least two of the following: state anxiety, trait anxiety, or total mood disturbance. According to this definition, 6 of the 13 feedback patients could be classified as improved on feedback day 6; 4 of 13 were improved on self-practice day 6; and 4 of 10 were improved on self-practice day 14. One of 8 patients in the comparison group was improved on feedback day 6. None of the comparison patients met the criterion for improvement on self-practice days 6 or 14. In addition, 2 feedback patients were able to use EMG relaxation to abort tension headaches and 3 were able to substitute EMG relaxation for nighttime medication to relieve occasional sleep-onset insomnia.

Medication Records

Medication was decreased for 2 feedback patients during the study—10 mg doses of trifluoperazine hydrochloride (Stelazine) given twice daily to 1 patient and 50 mg of chlorpromazine (Thorazine) daily to another patient were discontinued. Eight feedback patients had no change in medication—3 were on 5 mg of diazepam (Val-

ium) three times a day, 4 were on 100 mg of chlorpromazine twice a day, and 1 was on 10 mg of trifluoperazine hydrochloride twice daily. Two comparison patients had changes in medication—5 mg of diazepam twice daily was changed to 5 mg three times daily for 1 patient, and a dosage of 5 mg of trifluoperazine hydrochloride daily was increased to 5 mg three times daily for the other. Medication for the remaining comparison patients was unchanged during the study—4 were on 10 mg of diazepam three times daily, 1 was on 10 mg of trifluoperazine hydrochloride four times daily, and 1 was on 25 mg of thioridazine (Mellaril) daily.

DISCUSSION

The results for the feedback group indicate that successful EMG relaxation is accompanied by significant decreases in mood disturbance and anxiety test scores and is thus an effective adjunct therapy for chronic anxiety. The results of this study suggest that this type of therapy is as effective as one frequently used technique, group psychotherapy, and that with certain refinements in training procedures it may come to have greater efficacy than was demonstrated in this study.

Our limited access to the patients dictated a shorter training period (three hours of feedback plus five hours of taped instructions) than we would have chosen had there been no time restrictions. Raskin and associates (3) required an average of six weeks of five one-hour training sessions per week to achieve the 2.5 μV criterion considered optimal for maximum benefit (7). Within the feedback group, anxiety and mood disturbance scores were in general downtrends during training, and since the patients had not yet reached the 2.5 μV level of frontalis EMG, it is possible that continued training would have resulted in further improvement.

Another factor is that in order to minimize effects not directly due to the EMG relaxation training, patients were given a neutral instruction set with regard to what results to expect from the feedback training. A recent study (8) showed that positive instructional set can produce significantly more rapid learning of another biofeedback procedure, peripheral vasodilatation, than a neutral instructional set.

Because individual differences appear to be a significant variable in learning EMG relaxation (9), development of a predictor for success in EMG relaxation training would seem to be important for the successful clinical application of this technique. Examination of both initial level and change from baseline during training for EMG, mood, and anxiety scores failed to disclose unique characteristics for those who maintained their improvement after termination of feedback training and those who regressed toward baseline values. Future research should be directed toward development of independent prediction criteria of success in biofeedback training, such as demographic or personality variables, e.g., inward versus outward orientation (10).

Follow-up data on the feedback group are limited. It was possible to maintain contact with 2 patients for approximately six months after the study ended. Both have continued self-practice and use of the instructional tapes and have retained the ability to produce EMG levels at or below their self-practice day 14 level. While their reports are anecdotal at best, both patients said that relaxation training had enabled them to make adjustments to life stresses that they had not been able to make previously. Based on results from other EMG relaxation studies, it is expected that the ability to produce low EMG levels and accompanying decreases in anxiety and mood disturbance would continue as long as the patient practices regularly (3, 11).

The effect of EMG relaxation training in alleviation of tension headaches and sleep-onset insomnia is a finding that has been noted in other studies (3, 9).

In conclusion, we can say that in an intensive short-term training period, relaxation training was at least as effective as group psychotherapy in reducing both objectively and subjectively determined levels of anxiety and mood disturbance. With a more complete training program and development of better patient selection criteria, we would expect feedback-mediated EMG relaxation training to be substantially more effective than it was shown to be in this study and an important addition to the therapist's armamentarium for treatment of chronic anxiety.

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A Biological Basis for the Oedipus Complex: An Evolutionary and Ethological Approach

BY A. DAVID JONAS, M.D., AND DORIS F. JONAS

The authors propose that the Oedipus complex has a strong biological basis that is evident in observations of human prehistoric and nonhuman primate behavior. The groundwork for the oedipal phase is the peaking of human infantile sexuality at age five or six—a vestige of an earlier biological timetable. Other contributing factors include the high level of helplessness of human infants, the resulting high attachment needs, and the prolongation of developmental phases. Unsuccessful resolution of the oedipal phase may result when the mother's dominant status is lowered. The authors suggest that an understanding of the relationship between sex and rank and an awareness of ethological findings can broaden psychodynamic formulations and enrich the psychoanalytic therapy of sexual problems.

AS KNOWLEDGE ACCUMULATES, it not only adds to but modifies the existing store, and entirely new ideas emerge. Ideally, knowledge is the outcome of a continuously evolving process. Thus when theoretical constructs in any discipline become so static as to be considered dogma, it is necessary to reexamine the bases of the accepted assumptions.

We derive psychodynamic formulations from the ulterior significance we attribute to human activities rather than from actual sensory perceptions of these actions. Psychodynamic formulations generally have had no biological bases. They were axioms to be accepted as articles of faith—a faith made tenable because these axioms seemed to have useful therapeutic applications. The existence of myths and other ethological material that support many of these intuitively derived formulations has contributed to their acceptance and has often provided them with labels. One such myth, highlighted in Sophocles' trilogy about Oedipus and repeated in the folklore of many peoples, reveals the workings of timeless responses deeply rooted in man's development.

When we adhere to a fundamental belief in causal sequences, we are obliged to search for causal antecedents of behavioral manifestations. However, recent ethological and evolutionary findings have broadened the bases for understanding human phenomena. Following the lead of the physicists, we are beginning to abandon the simplistic (albeit workable) cause-and-effect concept in behavior. In its place, we view events as the outcome of probabilities that certain responses are likely to occur when internal mechanisms are released. The internal mechanisms form a complex nexus of phylogenetically encoded engrams that combine with ontogenetically acquired responses. The frequent contradictions in theories of abnormal behavior are probably due to the observer's tendency to focus on only one or a few features of the highly complex sequences responsible for our social adaptation.

Although Darwin's *On the Origin of Species* (1) was available during Freud's time, acceptance of the idea of man's place in and derivation from the rest of the animal world was still largely limited to his anatomical structure. While Darwin had opened the way to placing man's psychological development into the context of biological evolution (2), the significance of his work was not appreciated until ethologists quite recently confirmed the soundness of its concepts. In Freud's time the mind, or psyche, was considered to mark the boundary between animal and man.

Today, however, the painstaking and slow amassing of observational data gained from lifetimes of what Lorenz (3) has called "staring at" animals (an equivalent of the psychoanalyst's "listening to" humans) has provided us with a mountain of evidence on the continuities of human emotional and behavioral patterns with the animal patterns from which they derive and on some of the fundamental commonalities of all living creatures.

Years of studying ethological observations have convinced us that many of the original psychodynamic formulations, without their initiators' knowledge, were so soundly based that they stand up under the scrutiny of modern knowledge and are in fact confirmed and substantiated in the process. From the welter of possible examples, we have chosen the concept of the Oedipus complex for discussion, since we believe that it most clearly points up the ideas we wish to present.

THE INCEST TABOO

Freud (4) recognized a taboo against incest as a behavioral universal in modern man, and he sought its origins in primitive social custom. As he found the taboo to be

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universal there also, he sought to glean its source in myths surviving from prehistory. He traveled in the right direction, but the dearth of available information at the time prevented him from continuing far enough on this path. Ethologists' observations of the social behavior of living nonhuman primates indicate that mechanisms which tend to obviate incest probably existed even in the primate forms which were the precursors of man. In fact, we find that throughout nature—not only in the animal world but also in the plant world—natural selection has tended to preserve those mechanisms which prevent inbreeding.

The most significant mechanism that promotes the avoidance of incest among nonhuman primates is the dominance factor. All adult apes and monkeys, both male and female, are dominant over all immature juveniles. This relative standing tends to persist between the newly mature male and his mother. Since a male primate is usually unable to perform sexually with a female of higher rank because of hormonal inhibition, this single factor is an effective barrier to copulation between son and mother (5). The dominance factor does not, however, inhibit mating between father and daughter, and this could be a clue to the greater importance given in psychodynamic theory to the Oedipus than to the Electra complex.

Although the dominance factor forms the primary barrier to son-mother incest in nonhuman primate social groups, it is not the only one. As is characteristic of most important mechanisms, this factor is reinforced at several levels. For example, as the young patas monkey matures, he is often driven from his group by the strongly organized female hierarchy, perhaps to join an all-male party or, if he is the offspring of a female of high rank, to form a new group of his own (6). Groups of peripheral males in both rhesus (7) and Japanese macaques (8) are also sometimes separated from troops under the stress of threats from within. The exclusion of young males from hamadryas baboon reproductive groups is effected by the differential treatment accorded to the juveniles of the two sexes by the adult male group leaders. Young males soon learn not to expect protection from the adult males and to associate primarily with males of their own age within the herd or troop. They later appropriate young immature females (in which the dominant males are not yet interested) from existing troops (6).

These are but a few of the incest-inhibatory social usages, which are as many and varied as the species that practice them—but all tend to prevent son-mother incest by removing the young males from the presence of their mothers at the approximate time of their maturity.

MATRILINEARITY

Matrilineal kinship is the prevailing form of nonhuman primate social organization. With the exceptions of the gibbons and siamangs (small apes) and of the tiny South American titi monkeys (in which social groups are formed of monogamous pairs of adults), the mother has the complete task of nurturing and rearing the young. The father plays no individual role in this activity, although he of course participates collectively in species like the hamadryas baboon, in which dominant males are the effective protectors of all females and young (9).

One is tempted to ascribe the nonparticipation of the father in the rearing of the young among nonhuman and some primitive human groups to a lack of cognitive awareness of the paternal role, but further consideration reveals that this is not the case. The helplessness of the newly hatched chick in many bird species has promoted pair bonding between parents, and in these species the father shares in nurturing and rearing the nestlings. Thus we see that the acceptance of paternal responsibilities has more to do with whether pair bonding exists than with any cognitive awareness of fatherhood. In species in which the father does not assist in the rearing of the young, it is not unusual for the whole group (or tribe) or some of its members to assist the mothers.

So long as the precursors of our own species and its early members were organized into hunting bands, their social interrelationships would have been based on the subgroup formed by the mother and her children. When hunting gave way to an agricultural economy, the extended family unit came into its own. With the advent of industrial economies, this extended family was whittled down to the nuclear unit that is prevalent in the Western world today. Within this unit, the Electra complex began to take on a significance rivaling that of oedipal conflicts.

DEVELOPMENTAL PHASES

It is not without interest that human infantile sexuality reaches a peak at the age of about five to six, shortly before a period of latency begins. This coincides with the age at which the ovaries, although functionally immature, achieve the full adult size of 27 by 12 mm, which suggests that full developmental and functional maturity may have been reached by the age of about five at an earlier period in the human phylogeny. Circumstantial support for this conjecture might be advanced on the basis of medieval practices. In the Middle Ages adolescence was barely recognized, and the child of six was treated as a miniature adult (10). Indeed, even today it is not unusual in agricultural economies for a six-year-old child to be assigned farm or domestic duties and thus to be absorbed into the adult economy.

The process underlying the evolutionary development of the entire primate line, which reached a crescendo in the hominid line and resulted in its separation from the ancestral stem, is characterized by the prolongation of developmental phases. All developmental stages, from gestation to old age, have been progressively prolonged, but the most significant in the molding of our species has been the inordinate prolongation of the phase of childhood dependency and learning. This process, however, is still functionally and anatomically incomplete, and we retain such elements of the earlier timetable as the sexual

interest of children at the age of four to five as well as the full growth of the ovary by the age of five. It is our belief that these vestiges of a phylogenetically earlier timetable form the biological basis for the observed phenomena that have been formulated into the concept of the Oedipus complex.

ATTACHMENT BEHAVIOR

Important as the prolongation of developmental phases is as a biological base for the Oedipus complex, it is by no means a complete explanation for so complex a manifestation. Other elements meld with it in a multifactorial system of interactions and responses. Not the least of these is the high degree of helplessness of the human child, which necessitates a high level of attachment behavior (11). In early infancy this attachment behavior is purely self-preservative; to attach libidinal significance to it at this stage is redundant. One should not confuse the infant's gratification of the needs of its neural pleasure centers with sexuality. That the focus of attachment behavior is transferred at later stages from the parent to the mate and that it eventually forms a basis for and part of adult love and bonding is a separate matter. One might define the initial life-preserving stage of attachment behavior as a preadaptation for its eventual sexual function. This would represent a second strand in the cord of developing sexuality, one that begins to shade into or take on an incipient sexual element as it entwines with anatomical sexual development around the age of five.

THE DOMINANCE FACTOR IN HUMANS

The dominance factor is a third strand in developing sexuality. As we have mentioned, the normal dominance of adult primates over juvenile primates is usually sufficient to inhibit son-mother incest in nonhuman species. It is clear that there is also a dominance factor in humans, wherein the mother is clearly dominant in relation to her children in their infancy. How is it, then, that a son may experience sexual feelings toward his mother at an age when his relationship to her is still plainly subordinate?

Here we must digress briefly and refer to Monroe's comment (12) that the fact that "normal" people find nothing in either their observation of children or their own memories resembling the Oedipus complex does not disprove Freud's position. "The unanalyzed neurotic manages to function successfully largely by active 'successful repression' of his Oedipus complex. The normal person has worked it through adequately, also with amnesia for the early longings and misconceptions."

There is no doubt in our minds on the basis of the evidence that an oedipal phase exists as a physiological concomitant of an anatomical vestige that provides a base or a rudiment for psychosexual development. Whether this phase has any significance for the "normal" individual is an interesting theoretical point, but it is not relevant to our discussion. However, since there is abundant clinical evidence of psychosexual malfunction arising from this phase, the concept of the Oedipus complex is justified as an operational tool. Whether the Oedipus complex does not occur or exists and is suppressed in normal men, we have to assume that in these cases the mother-son interaction was such that it did not lay the ground for psychosexual disturbance at a later time. When the mother's dominant status is lowered in some way, then the ground is prepared for the son to fail to resolve the oedipal conflict.

A mother's rank goes hand-in-hand with her inner feelings of self-esteem and self-confidence. When these feelings are diminished (because of, e.g., emotional immaturity, unsatisfactory marital relationships, or psychological or physical handicaps), she will display certain patterns of behavior, among which are the following: 1) inconsistency—alternately cajoling and punishing the child, 2) placing the child on equal terms with herself and arguing with him, 3) looking upon the child as a playmate, or 4) showing helplessness or any other pattern uncharacteristic of the mother role. When this happens, the child responds with behavior that demonstrates the breakdown of the mother's authority. What has transpired is that the child has sensed that his own rank is at least equal or perhaps superior to his mother's and, the distance between them being diminished or eliminated, the mother is on the level of his peers, where she becomes a possible and available love object. In such cases, the third strand of the cord of the son's sexual maturation does not combine with the other two in a harmonious way, and the natural son-mother incest inhibition is disturbed.

We have invariably found, in reexamining case histories of psychosexual disturbances, material indicative of a breakdown of maternal authority (13). Conversely, we have noted among our acquaintances that the sons of strong, authoritarian mothers have stable marriages and satisfactory socioeconomic achievement. They do not become patients.

There is, of course, a variation that would seem to run counter to our proposition. This variant is the "good son." His mother is usually an invalid, whose ills may be real or imaginery, or she is helpless and uses her helplessness as a manipulative tool. At an early age, the son is assigned the role of "mother's helper," and he soon becomes what we might call a "junior husband." Eventually, he becomes a pseudoparent for his mother. During the oedipal phase the child takes on the role of protector, which places him in a superior rank and would, according to our schema, make him susceptible to incestuous longings. If we add to this the seductive behavior that frequently accompanies this maternal pattern, the son finds himself obliged to repress or severely suppress any longings toward women in general. If the "good son" has a low sex drive, he becomes a primarily asexual bachelor. If his sex drive is within the normal range, he turns to homosexuality. Unquestionably the father is an additional variable in this constellation, but this factor is outside our present subject.

THE FATHER'S ROLE

A fourth strand in psychosexual development and in the Oedipus complex is the role of the father. The biological and evolutionary vestiges of the father's part in the Oedipus complex are easier to discern as a result of ethological observations in many species of the seasonal challenges by the rising generation to the established males. In some primate species—especially those most closely related to man—animals are sexual for a large part of the year (14), and dominance challenges are therefore not confined to particular seasons. The evolutionary basis of castration anxiety (which Freud considered an essential part of the Oedipus complex) may therefore be seen as a loss of sexuality that the primate male experiences in the presence of a dominant animal. Social practices vary among the various primate species and (as in humans) to some extent between geographically separated groups of the same species. The hamadryas baboon male, for instance, will not permit any other male to approach his females, whereas a dominant male chimpanzee may permit copulation in his presence with apparent indifference (although he normally exercises his prerogative at the time of the female's ovulation). Nevertheless, even in the comparatively open society of chimpanzees, whenever a dominant male choses to intervene a subordinate will abandon the female to him.

STATUS, SURVIVAL, AND PHYSIOLOGY

It bears emphasizing that, in terms of survival, it is just as important for the individuals in any group of animals to be programmed to give up when necessary as to be able to fight when necessary. If this programming did not occur, there would be nothing but fighting to the death, a state of affairs that obviously would not promote survival of the species (15).

To understand how this factor operates, we must examine the hormonal mechanisms that promote it. Very slight variations in quantity or, perhaps, quality result in the differences in each generation's competitions for status, although all individuals are endowed with basically the same hormonal equipment.

Recent research at primate centers such as the Yerkes Regional Primate Center of Emory University, Atlanta, Ga., has shown that there is a significant correlation between status in the group and testosterone production (16). It is difficult to determine whether enhanced hormone production leads to high status or vice versa. It is probable that, as in most organic states, there is a circular effect in which either leads to the other. In any case, it appears that an animal with high status and high aggression also has high testosterone levels.

When experimenters forcibly interfered with the social standing of a dominant animal (by physically restraining it, removing it to another compound where it had no established status, or by other means), its testosterone level dropped (16). On the other hand, when a lower ranking animal was given injections of testosterone, its aggressiveness was enhanced and its social status rose. Conversely, when a lower ranking animal was manipulated into higher status (by removing those that outranked it from its compound or by other means), its testosterone levels rose, showing a clear connection between sex hormone production and social status.

The lowering of testosterone levels with the loss of rank that we see in nature could be viewed as a form of castration. While the administration of testosterone in man does not affect sexual status in the same way, probably because of cultural factors, some vestiges of these responses may have been retained. The initial formulation of castration anxiety viewed it as a fear of the real or symbolic loss of the genital apparatus. As we see in other primate species, what is lost is not the apparatus but the power to use it. We also observe that there is a close connection between this power and the animal's sense of rank. Interestingly, castration anxiety more recently has been understood by the general public to mean a metaphorical loss of male rank. A woman who dominates a male is referred to as a "castrater." Conversely, high rank has a phallic connotation (Henry Kissinger has been quoted as remarking, "Power is the ultimate aphrodisiac").

There are certainly other factors than the four strands we have identifed as separate but entwined elements of normal or abnormal sexual development. Among them are those which derive from cultural bases. We have no wish to disregard the multiplicity of factors involved in behavioral determination or the feedback character of their interplay—it has been our purpose only to identify the evolutionary elements among them.

CONCLUSIONS

There appears to be a sound biological foundation for the concept of the oedipal phase and the Oedipus complex, including castration anxiety. This could be of more than theoretical interest, as a focus on the interrelationship between sexuality and rank could provide a broader basis for the psychoanalytic therapy of sexual problems. Also, a knowledge of evolutionary development and an awareness of ethological findings may contribute greatly to the understanding and broadening of other psychodynamic formulations.

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Prompt Publication Policy

The *Journal* would like to remind authors who are particularly interested in early publication (whether to establish priority of an idea, reveal innovative results of new research, or for other pressing reasons) of its prompt publication policy. Under this policy, short (maximum of six double-spaced pages) manuscripts will be considered for publication in the Brief Communications section of the first available issue. These manuscripts must still undergo expert scrutiny before being accepted, and two months must be allowed for the printing process. However, the time required for publication of these short articles can be lessened considerably.

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The Impact of Medical School on Future Psychiatrists

BY DONALD LIGHT, JR., PH.D.

Although psychiatry and clinical medicine share ideals about what distinguishes a good practitioner, medical schools do not select students on the basis of these qualities. Moreover, they seem to discourage many interested students from choosing psychiatry. Part of the problem is that psychiatry is poorly taught. Research suggests that psychiatry can be better taught and that medical students will be receptive. However, the clash between the values of technological medicine and psychiatry has created discouragement, with the ironic result that medical students rate psychiatrists poorly because they embody the very qualities that distinguish the good clinician.

EVERY PROFESSION has an ideal of itself. In recruiting, a profession seeks candidates who come closest to that ideal. In training, a profession shapes and polishes its recruits, putting forward its finest examples for the next generation to emulate. Most of us naturally assume that recruitment and training complement each other, but this is not always the case.

In psychiatry, for example, medical school is both a source of recruitment and a training experience. This double function makes it important to examine the impact of the medical school experience on potential or future psychiatrists. Because it intertwines the two professions, this relationship mingles the ideals and goals of medical recruitment and training with those of psychiatric recruitment and training. In this paper I will draw upon the relevant research and attempt to analyze some of these relationships.

The ideal doctor has not changed much over time. Levitt cited the description of the ideal student from *Samhita*, the Hindu book of medicine, as follows: "born of a good family, possessed of the desire to learn," and having "strength, energy of action, contentment, character, self-control, a good retentive memory, intellect, courage, purity of mind and body, and a simple and clear comprehension" (1). Recent descriptions of the ideal doctor are only slightly different. For example, one author stated that the ideal physician is "compassionate, sympathetic, perceptive and understanding and he likes human beings" (2). The qualities of the ideal psychiatrist are strikingly similar, suggesting an enviable compatibility between general medicine and psychiatry.

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PATTERNS OF SELECTION

In practice, however, a different picture of the medicine-psychiatry relationship emerges. Medical schools select students primarily on the basis of grades and test scores, with other idiosyncratic factors entering into the final selection. They do not, therefore, select for the qualities that make a good clinician; rather, they indirectly give preference to qualities that all too often accompany a strong premed record—an intense compulsiveness, intellectual narrowness, and, sometimes, difficulties in getting along with other people. By contrast, psychiatry begins with a pool of technically competent candidates and concentrates on selecting people who manifest qualities that distinguish a good clinician in any field.

This picture suggests that medical schools recruit against the best interests of both medicine and psychiatry, particularly in terms of primary care. A sensible remedy would be for medical schools to first screen out candidates whose scores are too low to be considered and then to use psychological tests and interviews for making the final decision. This would balance technical skills with the clinical ideals of the profession.

THE MEDICAL SCHOOL EXPERIENCE

The impact of the experience of medical school on potential psychiatrists was measured in a study at Tufts Medical School (3), where 58 percent of the freshmen expressed a high interest in psychiatry and 21 percent listed psychiatry as their first choice for a specialty, putting psychiatry in a tie for first place with surgery. However, by the fourth year, only about 10 percent of a given class entered psychiatry. Despite continued efforts to integrate psychiatry into medical training, particularly through the emphasis of treating the "whole man," studies indicate that medical school actually discourages interest in psychiatry. The ironic inference is that psychiatry rests its claims for professional status on a profession that is hostile toward it.

Faculty Influence

Does the problem lie with medical school faculty? Somehow it must, yet a careful study of faculty influence

found little evidence to this effect. When Coker and associates (4) asked a large sample of students from eight medical schools about the greatest influences on their career decisions, 54 percent mentioned informal faculty influences. Each student named faculty members who were most influential in various ways. When these responses were organized by specialty, professors of internal medicine were named six times more often than psychiatrists as someone a student would talk to about choosing a specialty and nine times more often as the person who had most influenced the student's view of medicine. Professors of psychiatry were chosen least often in every other category of influence—they were the lowest-ranked specialty regardless of how students were asked to rate faculty.

The paradox arising from the results of the Coker and associates' study is that the "influential" faculty did not seem to affect the medical values of the students who named them. A comparison of three groups of students—1) those who chose no faculty member as influential, 2) those who chose a faculty member who felt one way about any of a range of values, and 3) those who chose a faculty member who felt the opposite way—revealed that these three groups exhibited the same distribution of opinion about the values investigated. Other studies have also found that medical school does not influence professional values (5, 6).

More to the point is the influence of faculty on the choice of a specialty, particularly psychiatry. Here, Coker and his associates found that 53 percent of those few students who chose a psychiatrist as an adviser on career decisions also chose psychiatry for themselves, which is clearly higher than the percentage of students choosing same-specialty career advisers in internal medicine (27 percent) or surgery (38 percent). It could well be that these students had a commitment to psychiatry before they chose a psychiatrist as a career adviser, and there is some indication in the data that this is the case. More important, only 6 percent of the students chose a psychiatrist as the person to whom they would go for advice on selecting a specialty.

Thus, we have not found a specific cause in the faculty for the dramatic loss of interest in psychiatry during medical school. In fact, half of the professors in Coker and associates' study believed that students did not place enough importance on the development of warm relations with patients.

Although there is no evidence that faculty directly discourage students, the curriculum itself seems fundamentally hostile to psychiatry. Some argue that introducing more psychiatry into the curriculum is not enough. Galdston wrote,

> The now prevailing philosophy [in medical education] is Cartesian in derivation and atomistic in character. It fosters the dismemberment of man. What we need is a philosophy of medicine and of medical education that perceives man and understands him holistically, ecologically, and existentially. These may be odd terms, but they do encompass what is requisite for the modernization of medical education and medical service.
>
> The young medical man who comes to us for his residency training in psychiatry all too often brings with him a quantum of attitudes and beliefs which impede his learning of psychiatry. (7, pp. 990–991)

Influences of Pressure and Personality

On a more personal level, the gruesome pressures of medical school have long been known to require or generate qualities in medical students that are quite at odds with the profession's ideal of the physician. Successful students "are usually obsessive, compulsive, orderly, highly organized, responding primarily to the dictates of their own conscience" (1). MacDonald (8) found that the most frequent ideal among first-year medical students was that of a critical-sadistic person. Four common patterns of "adjustment" to medical school are 1) emotional constriction, 2) fierce concentration on grades, 3) manipulation of others to get ahead, and 4) high anxiety (1, 7). The incidence of pathology severe enough to require psychiatric assistance ranges from a minimum of 20 percent to a maximum of 46 percent in different schools. Levitt drew on 53 references to conclude,

> The brief historical and social portrait of the student from the beginnings of medicine onward plus the personal and professional expectations of him are presented to indicate the massive stress that is placed on an ego that is still in the process of becoming. The rapid technological advances and social demands constantly increase the stress and inexorably produce emotional turmoil in every student. (1, p. 210)

Several authors have focused on the rise of cynicism during the four years of medical school (9–12). This has been interpreted by Becker and Geer (13) as the process of medical students realistically adjusting their initial idealism to actual practice, but the cynicism scales that were used have little to do with such adjustment—they tap a more basic outlook on life. Moreover, general cynicism does not seem to increase in training programs in such fields as nursing or law (9), and thus it is not simply part of "maturity."

Since psychiatry depends so heavily on the personal strengths and resources of its practitioners, the assault by medical school on these qualities is an important aspect of recruitment into psychiatry. As Winnecott wrote,

> The doctor's long and arduous training does nothing to qualify him in Psychology and does much to disqualify him. It keeps him so busy from eighteen to twenty-five that he finds he is middle aged before he has the leisure in which to discover himself. (14, p. 116)

Although cynicism decreases after the student gets into psychiatry (15), considerable damage may have been done by that time.

Technology and Training for Humane Care

The general problem of training humane doctors and the specific tensions between psychiatry and medicine have not gone unnoticed. In a time of community practice, these problems go to the heart of good medicine.

Over the past two decades, there has been general agreement that a technological emphasis pushed humane care into the shadows of medical training. In response, scores of programs have been launched to bring psychiatric insights into the center of medical education.

A mood of optimism now pervades which suggests that the inhumane, antipsychiatric days are over. However, studies of what medical students actually learn are discouraging. A recent survey of five medical schools in Philadelphia revealed that half of the students believed that a person who talks about suicide will not go ahead with it, half believed that masturbation frequently causes mental illness, two-thirds thought a psychotic could not hold a job, and one-third believed that neurosis is diagnosed by excluding organic factors (16). Even when students do learn, they do not always apply their knowledge in practice (16).

MEDICAL STUDENTS' OPINIONS OF PSYCHIATRY

Psychiatry is rated as one of the most poorly taught specialties (4, 16). Graduates of 41 American and Canadian medical schools cited a lack of discernible purpose, poor organization, lack of coordination with clinical experiences, and poor teachers (16). Much of the teaching is done by lecture, and 20 percent of the respondents said their clinical experience amounted to observing demonstrations. The majority never began or completed the treatment of their clinical cases. Thirty-six percent reported little or no supervision, and 38 percent felt they had received no guidance from supervisors. Despite such discouraging experiences, half of the physicians said they needed more psychiatry to practice medicine well, and three-fourths said they enjoyed trying to understand a patient's problems. In these data, we again find a stifling of widespread interest, but we also find a clear mandate: make psychiatry a living clinical experience with excellent supervision (16–18).

The experience of psychiatry and its image in medical school influence students' perspectives on the profession and therefore have an influence on who will decide to enter it. In general rankings of medical specialties, psychiatry rates low (18–21). Students rarely give psychiatry as a second choice; it is a first choice for some, but a third or lower choice for everyone else.

Psychiatrists are seen as less competent and more likable than surgeons or internists. For example, medical students in one study considered psychiatrists to be less clear thinking, less realistic, and less alert than the other two groups of specialists—but they were also considered less rigid, less arrogant, more easygoing, and more sensitive (18). A three-week clerkship in psychiatry reinforced both sides of this perspective:

> The greatest changes were in the students' perceptions of the *style of relationships* that psychiatrists form. Not only were the psychiatrists . . . seen as more considerate, friendly, gentle, and informal, but they were also perceived as being more appreciative, calm, humorous, and relaxed. (18, p. 251)

The point is that the very qualities that give psychiatry a low rating among medical students, who esteem competence and boldness, are in fact the marks of competence in psychiatry. Thus, medical students perceive psychiatry with some accuracy, but from the hostile perspective of technical medicine.

The results of other studies reflect an even more negative image of psychiatry among medical students (11, 12). One reseracher followed a small group of students for four years and found that their evaluation of a full range of psychiatric treatments, from electroconvulsive therapy to psychotherapy, worsened significantly over that time (12). Another study examined medical students' opinions of various specialties and found that only psychiatrists were characterized as deeply interested in intellectual problems, yet they were also described as confused thinkers and as emotionally unstable (11). More clinical experience led these students to see psychiatrists as less intellectual and more confused. Overall, their views were similar to the public's ideal image, even though they had worked closely with psychiatrists.

WHO CHOOSES PSYCHIATRY?

Amid these reports of bad teaching, low status, and a poor image, one must ask, What kind of person retains an interest in psychiatry? He/she claims a great interest in intellectual problems and research, although his/her academic record may not be distinguished (11, 22). In one study, psychiatric students scored high on complexity of thought and on introversion (11). Students with a strong interest in psychiatry are also less committed to medicine and more likely to have considered another career than other medical students. Their decision is more likely to have been their own rather than one that was encouraged by their family (3, 9, 22).

As a group, potential psychiatrists are more anxious than other students in medical school. However, there are probably significant differences within this group, particularly between those who decided early to become psychiatrists and those who wanted to become doctors but found they liked psychiatric work more than other medical practice. The first type of individual is intellectual, probably captivated by the psychoanalytic theory of mind, and enters medical school primarily as a means to becoming a psychiatrist. He is less likely to be uncertain and anxious than the late decider, who vacillates and essentially changes his career and his self-image in midstream (23). However, some early deciders may be more anxious, cynical about what they see happening in medicine, and isolated from the general student culture (3, 24).

Candidates for psychiatry score low on measures of prejudice and of authoritarian attitudes (20, 21, 25, 26). Low authoritarianism is in turn linked to low scores on aggression and orderliness and high scores on introspection and nurturance. Moreover, authoritarianism is inversely related to admiration for psychiatry. Thus, nonauthoritarian students score high on qualities valued in psychiatry, are more likely to admire psychiatry as a

specialty, and also emphasize understanding as an important attribute of a good physician. This research should be viewed in relation to findings that most medical students do not like psychiatric patients because they are not friendly and cooperative, and most prefer not to treat patients with emotional illnesses (6).

Another trait found among potential psychiatrists is high death-anxiety, which is again inversely related to authoritarianism. Livingston and Zimet (21) discovered that medical students' defense regarding working around dying people comes not from learning detached concern but from their own personalities. Anxiety about death does not decrease during medical school—it actually increases in the third year, indicating that early work with cadavers and experimental animals does not prepare sensitive students for working with human patients. Different kinds of personalities sort themselves out by specialty, with psychiatry and pediatrics getting a preponderance of nonauthoritarian students with high scores on death anxiety. Livingston and Zimet also pointed out that extremely nonauthoritarian as well as authoritarian personalities can prevent stable, anxiety-free relations.

> Too much authoritarianism distorts the physician's sense of reality and renders him incapable of a beneficial relationship with his patients; too little makes the physician liable to doubts, extreme introspectiveness, and a pathologic sensitivity that makes him unable to retain the detachment necessary for useful service to a suffering human being. (21, p. 229)

Livingston and Zimet summarized the research in this area when they stated, "The inability of a medical student to view a patient as a 'whole man,' as psyche and soma, is not an isolated trait but part of a whole personality syndrome characterized as authoritarian" (21, p. 224). This observation has multiple implications for selection into both medicine and psychiatry. First, aside from extreme cases, the students who would be the best practicing physicians ironically are the most likely to be turned off by medical school and to be oriented toward psychiatry. Second, at a time when psychosocial functions of medical care are seen as very important, medical schools are not selecting students on the basis of personality traits and therefore may be admitting many students who will not perform these functions well (27). (Note, however, that when medical schools choose women over men, they are more likely to get students who are independent but not aggressive, sensitive and emotionally expressive but strong [28].) Finally, it seems psychiatry gets many of the candidates it wants only because they slip into medical school on other merits.

CONCLUSIONS

By insisting on a medical degree, psychiatry finds itself in the awkward position of letting another profession select its pool of candidates on different if not counterproductive grounds. Then, the medical school experience may discourage many of those interested in psychosocial problems from choosing psychiatry. From the larger perspective of health care, however, it is medical school that emerges as a pathological institution which selects students on the wrong criteria and downplays the qualities long esteemed in clinical work.

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Computer Content Analysis of Schizophrenic Speech: A Preliminary Report

BY GARY J. TUCKER, M.D., AND STANLEY D. ROSENBERG, PH.D.

Computer analysis significantly differentiated the thematic content of the free speech of 10 schizophrenic patients from that of 10 nonschizophrenic patients and from the content of transcripts of dream material from 10 normal subjects. Schizophrenic patients used the thematic categories in factor 1 (the "schizophrenic factor") 3 times more frequently than the nonschizophrenics and 10 times more frequently than the normal subjects ($p < .01$). In general, the language content of the schizophrenic patient mirrored an almost agitated attempt to locate oneself in time and space and to defend against internal discomfort and confusion. The authors discuss the implications of this study for future research.

AS THE TREATMENTS for psychiatric illnesses have become more specific, we have seen the interest of psychiatrists return increasingly to the phenomenology of mental illness. Regardless of the patient's own history, family history, or even the presenting clinical picture, we place a great deal of emphasis (as Rosenhan's widely publicized recent study has shown [1]) on precisely what the patient tells us or complains of. However, there is probably no phenomenological area more difficult to study in a systematic way than the mass of verbal productions that a patient presents to us. There have been many attempts to study the language of patients, particularly of schizophrenics. Most of these studies have focused on two areas: the evaluation of the formal or structural aspects of language (grammar, syntax, etc.) (2, pp. 469–503; 3; 4) and the examination of content or thematic differences (5–10). The latter is the research technique most closely akin to the clinical interview and to everyday practice.

While clinical experience argues that an understanding of language characteristics is crucial to a phenomenology of psychosis, a number of difficulties have limited progress in this area. Quantitative studies of the form or content of language have traditionally required many laborious hours of scoring and have struggled under the burden of attempting to establish reliability without sacrificing meaning (2, pp. 469–503; 5; 7–10). Most quantitative analyses have focused on material written by patients (which may be very different from free speech), and most have used scoring techniques that require many subjective judgments.

However, whether they focus on content or formal structure, all of these studies ask the same question: What makes this speech "crazy," "unique," or "different"? There must be something in the free speech of these patients that we can characterize. Brown (11) recently noted that even the most bizarre or delusional content can be made credible and lose its "crazy label" if we preface it with the statement, "I dreamt." At the same time, it seems that the spontaneous verbal productions of the prospective patient are a primary cue that clinicians use in their decision to affix the diagnosis of schizophrenia to a given case. Moreover, this diagnosis is a fairly common one. There is something (or a combination of things) that a person can say to make the clinician infer that he suffers from schizophrenia. We are concerned with specifying the linguistic cues that the patient presents to trigger this inference.

In our study we have tried to combine modern computer methods and analysis with a phenomenologic study of the experience of schizophrenic patients as expressed in their free speech. We have attempted to answer the following questions: 1) Can the content of schizophrenic speech be differentiated from that of nonschizophrenic speech as well as from the content of dream material? 2) Can a reliable, objective, and simple technique to do this be devised through the use of modern computer technology?

METHOD

Subjects and Setting

The subjects included in this study consisted of the following three samples: 10 schizophrenic patients, 10 nonschizophrenic patients, and 10 normal subjects. The technique used in the selection of these subjects and the interview method have been previously reported (8–10).

The only criteria for the selection of subjects focused on making the three groups comparable in age, sex, and social class. The normal subjects were selected on the basis of 1) exhibiting no overt pathology and 2) demographic similarity with the two patient groups. The schizophrenic and nonschizophrenic patients were sequential admissions to the acute inpatient service of a general hospital. The diagnosis of these patients was arrived at by

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consensus of two clinicians, who classified the patients according to APA diagnostic criteria (12) as well as by the New Haven Schizophrenia Index (13). The diagnoses of the nonschizophrenic patients included neurotic depression, character disorder, etc. All of the patients could be classified as acutely ill, and the schizophrenic patients would be classified as reactive- rather than process-type schizophrenics. Each of the three groups consisted of 5 men and 5 women. The median age of the three groups was 20 years, and the subjects fell into the range of lower to upper middle-class.

The transcripts of dream material from the normal subjects were obtained as part of a larger study of the normal dream activity of individuals who were participating in sleep studies.[1] The subjects were awakened after they had experienced 10 consecutive minutes of rapid-eye-movement sleep and were asked promptly to describe their dreams. The transcripts from the patients were randomly selected from a larger sample of transcripts previously collected (8–10); they were obtained during a standardized 15-minute interview during the patients' first week of hospitalization. All of the patients were given the same instructions; after this introduction the interviewer, an experienced psychiatrist, spoke only when he thought it necessary to encourage the patient to continue talking, and his comments were limited to that goal. This technique has been previously described and used in other studies (8–10). The tapes were then transcribed to typescripts and corrected by the interviewer prior to content analysis.

Content Analysis

These samples of free speech were analyzed through the use of a Dartmouth adaptation of the General Inquirer Computer Content Analysis Program and the Harvard III Psychosocial Dictionary (2, 14). Although many of the transcripts were fairly long, only 600 message units or about 600 words were placed into the computer for each subject for analysis. This limitation was imposed by the storage capacity available to us. To ensure comparability and prevent selection bias, the first 600 words of each transcript were used, and this generally represented a large percentage (usually more than two-thirds) of the entire interview.

The General Inquirer Computer Content Analysis Program simply allows these typescripts to be processed by the computer so that they can be grouped into various thematic categories depending on the dictionary that is used. The General Inquirer program is actually a series of programs that does such things as arrange the words into alphabetical order, remove suffixes such as "-ed" from words, and allow these words to then be searched for in various available dictionaries. The Harvard III Psychosocial Dictionary allows 3,500 words (most of the words used in everyday speech) to be placed into 84 thematic categories that have been specifically selected for their psychological and sociological relevance (see appendix 1). They cover such areas as emotional states, thoughts, evaluation, and cultural objects and settings. A fuller description of the programs and the dictionary can be found in *The General Inquirer* (2). Using this technique we were able to "tag," or categorize, over 90 percent of the words used in these typescripts.

Data Analysis

The output of these computer programs can be listed as the combined frequency of the appearance of words in each of the 84 thematic categories. The program also has the capability of identifying specific sentences in any of the typescripts and also the appearance of specific thematic categories in any sentence in the typescripts. Consequently, individual themes and sentences can be examined in their actual context. The combined frequencies of the three groups of subjects were then studied by a one-way analysis of variance and a factor analysis. In this particular study we were concerned with each subject's range of vocabulary rather than his possible repetition of any given word. The issue of repetition of words in schizophrenic speech has been previously studied (15). Consequently, our analysis was based on the subjects' initial use of each word but disregarded the subsequent use of the same word. Later studies will examine the relationship between the range of vocabulary and repetition of words.

RESULTS

Thematic Categories

Seventeen thematic categories significantly differentiated among the speech samples of the three groups (table 1). Fourteen categories significantly differentiated schizophrenic patients from nonschizophrenics. These categories can be grouped into the following three general areas: those that represent 1) heightened emotional states, such as the categories of avoidance, attack, overstatements, and sense; 2) orientation to people in the environment, with categories denoting such things as references to space, time, and sensation; and 3) attempts to explain their condition, with categories such as get, cause, ought, and self.

The nonschizophrenic patients were significantly different in their more frequent use of the categories of ideal, if, and medical. It is interesting that the dream subjects scored significantly higher on only the category of urge. This category includes such terms as drive states, dream, eager, and incentive. If we now look at the magnitude of mean differences among the groups, we see that in 10 categories the dream subjects and nonschizophrenic patients were more similar to each other than they were to the schizophrenics (see table 1). In many ways, then, it appears that speech content associated with schizophrenia is less like the content of dream material than we might assume. The dream subjects used 5 categories much less often than the two patient groups (self-reference, ideal-value, if, cause, and medical); the nonschizophrenic patients' use of 2 of these

[1]These transcripts were provided by Dr. Peter Hauri, Department of Psychiatry, Dartmouth Medical School.

TABLE 1
Frequency of the Categories Significantly Differentiating Among the Three Groups

Category	Nonschizophrenics	Dream Subjects	Schizophrenics	Level of Significance*
Self-reference	2.80	1.60	3.80	p<.008
Neuter role**	1.40	1.20	2.50	p<.03
Time reference**	10.30	7.90	17.50	p<.01
Space reference**	7.40	7.50	11.00	p<.08
Ideal-value	3.00	1.60	2.90	p<.08
Urge	0.50	1.40	1.00	p<.04
Sense**	2.00	2.80	4.10	p<.07
If	3.50	1.80	3.20	p<.05
Equal	0.60	0.10	1.00	p<.08
Cause	1.70	0.90	1.90	p<.02
Ought**	0.50	1.00	1.80	p<.06
Attack**	0.40	0.90	2.30	p<.02
Avoid**	1.00	0.60	2.20	p<.03
Attempt**	0.50	0.30	1.40	p<.02
Get**	3.70	2.60	5.00	p<.04
Medical	1.70	0.20	1.10	p<.002
Overstate**	7.50	5.20	10.90	p<.002

*By analysis of variance.
**Significantly differentiated schizophrenic patients from nonschizophrenics and dream subjects.

categories (self-reliance and cause) fell between that of the other two groups. In general, dream content is less similar to schizophrenic content than it is to the speech of hospitalized nonschizophrenics.

Delineation of Factors

All of the trends indicated by the analysis of variance were confirmed by factor analysis. What seems to emerge could be called a "schizophrenic factor" (table 2). Taken as a whole, factor 1 (schizophrenic factor, Eigen value= 12.2) represents categories that were used 3 times as frequently by schizophrenic patients as by nonschizophrenics and 10 times more frequently by schizophrenics than by dream subjects. In referring back to our analysis of variance, 7 of the 12 categories that load on factor 1, including the 4 with the highest factor loadings, significantly differentiated the three groups. Schizophrenic patients exhibited the highest mean scores on each of these variables. Moreover, analysis of variance of the factor scores significantly differentiated the three groups ($F=5.04$, $p<.01$). Factor 1 accounted for 38 percent of the variance in category usage. This latter figure is quite high when one considers that the dictionary contains so many categories, and it is also high compared to past studies of other types of data using this same dictionary (2, pp. 469–503; 7; 15).

If we examine the schizophrenic factor, it becomes apparent that the schizophrenic patient—by his very choice of vocabulary—is telling us about his experiential state. That is, he is exhibiting a heightened concern with the self in a context of distress and disorientation. Moreover, his concerns seem to be grounded in an inability to find an appropriate stance in the interpersonal environment. For example, the schizophrenic both attacks and avoids others. His use of overstatement, as well as time and space references, bespeaks an agitated need to locate the self. Such findings are highly congruent with the descriptions of those who have worked intensely with schizophrenic patients (16–18).

The therapist who attempts to enter the interpersonal field of the schizophrenic patient finds that he will continually approach and then flee. He often pursues closeness itself by such primitive means as aggression or fantasies of devouring the therapist as a means of magical incorporation. The patient struggles to find an acceptable level of intimacy, feeling alternately threatened by closeness and fearful of distance. It has been repeatedly stated that the obviously schizophrenic individual has severe boundary disturbances that make the presence of another person highly threatening and that also make time and space insubstantial for him. This sense of being unanchored in a chaotic universe is generally quite terrifying. Our acutely ill patients may be seen as grappling with this experience of psychotic disorganization. Their condition seems to represent not so much a suspension of or defect in ego processes as an attempt by the embattled (and perhaps defective) ego to survive in the face of extreme stress. It may be that they move toward specificity and overstatement to counteract their fear of dissolution and chaos. Self-reference may increase as an antidote to the fear of loss of the sense of self.

Factor 2 (table 2) seems to denote themes relating to attempts to explain and in some sense negate this condi-

TABLE 2
Factor Analysis of the Speech Samples of the Three Groups

Factor and Categories	Loading
Factor 1	
Other	−.57
Think	−.57
Overstate	−.66
Time reference	−.70
Get	−.70
Distress	−.73
Move	−.75
Peer	−.76
Avoid	−.77
Space reference	−.81
Attack	−.84
Self	−.87
Factor 2	
If	−.36
Move	−.40
Ought	−.42
Think	−.43
Other	−.46
Work	−.62
Academic	−.72
Not	−.77
Higher status	−.78
Factor 3	
Community	−.86
Attempt	−.52
Urge	−.37

tion. Factor 3, which represents a very small factor, is less clearly understandable in theoretical terms. Although the themes in both factors 2 and 3 were used most frequently by the schizophrenic patients and showed a tendency toward significantly differentiating this group from the other two groups, most of them were not statistically significant. Perhaps by increasing the sample size they will eventually be brought to a significant level.

DISCUSSION

In terms of the questions we asked, it does seem possible to differentiate schizophrenic speech from nonschizophrenic speech on the basis of content or thematic material alone. It is of interest that the picture which emerges, particularly from factor 1, seems to be consistent with clinical experience in that the content analysis revealed a person who is experiencing a high degree of self-concern linked with confusion and distress. The content mirrors an agitated attempt to locate oneself in time and space and vividly portrays internal discomfort and attempts to counteract the fear of others and the environment. It is also interesting that the themes differed markedly from those in the transcripts of the dream subjects. The dreams were included in order to evaluate the similarity of dream content to the schizophrenic state. Both conceptually and descriptively, many writers (16–18) have likened the acute schizophrenic state to a dream in that both represent a breakdown of ego processes and a subsequent outpouring of primary process material.

The marked difference that we found between the two raises many questions about precisely where one finds the closest analog of primary process thinking. It clearly does not appear that dream material is so distinct thematically or in terms of content. Perhaps it is the structure of dream material that makes it appear so distinctive to us. That is, it may exhibit such characteristics as condensations, time shifts, and symbolic meanings, while the content itself is not that remarkable. Conversely, the content of the speech of the schizophrenic patient is itself quite distinctive aside from its structural features. It conveys itself to the clinician as confusion, internal and external fears, and extreme ambivalence. Given these content cues, the listener may secondarily begin to look for structural distinctions such as looseness of associations, blocking, etc. Consequently, the structural defects that are reported (often at different times or not at all) may be arbitrary distinctions made by the clinician after he is oriented to a schizophrenic diagnosis by the distinctive content of the patient's speech.

The picture of the patient as represented in the content analysis—that of a person who is preoccupied with orientation and is to some degree confused—is in itself interesting and similar to the picture of a patient with an organic brain syndrome. In previous studies we have demonstrated that the thinking disturbances noted in schizophrenic patients are often related more to minor neurological impairments than to the specific diagnosis of schizophrenia (19, 20). Interestingly, Gottschalk and Gleser (5), who used a content analysis technique, could differentiate schizophrenic patients from all other diagnostic groups except that of organic brain syndrome. The use of this technique in future research that compares patients with organic brain syndrome and schizophrenia might further clarify the meaning of these findings.

In answer to our second question, this technique can be used reliably and simply once it is set up and in operation. It clearly obviates the problem of depending on judgments by human scorers. The technique seems to be capable of simply and objectively analyzing large amounts of verbal material. However, the importance of the technique is not in the preliminary results so much as it is in the following implications for future research:

1. It may be used in the evaluation of treatment techniques and patients in remission.
2. It may be useful in comparing schizophrenic patients with patients suffering from other psychotic states such as the manic type of manic-depressive illness and, particularly, mild organic brain syndromes.
3. It permits easier comparison of existing psychopathology and verbal content with age, sex, chronicity of illness, and social and cultural differences.
4. Formal diagnostic criteria might eventually be available through content analysis itself.
5. It is possible that a model of schizophrenic speech can be developed through the use of this technique.

Since we have now built in the capability to retrieve words, categories, and sentences, an analysis of various clinical theoretical constructs about the psychology of schizophrenia (such as the relationship of anger to self and others) can easily be pursued.

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APPENDIX 1

Brief Definitions of the Thematic Categories of the Harvard III Psychosocial Dictionary (Partial List)

SOCIAL REALM

Persons
- Self: pronoun references to the personal self
- Selves: pronoun references to the inclusive self
- Other: non-sex-specific pronouns for other

Roles
- Male role: roles with specific male references
- Female role: roles with specific female references
- Neuter role: role names not connoting sex or occupations
- Job role: roles with clear occupational reference, theoretically open to both sexes

Collectivities
- Small group: groups in which members are usually able to have face-to-face interaction
- Large group: collectivities usually too large for face-to-face interaction

CULTURAL REALM

Cultural objects
- Food: articles or types of food
- Clothing: articles or types of clothing
- Tools: instrumental objects or artifacts of any kind

Cultural settings
- Social place: buildings and building parts; political, social, and economic locations

Cultural patterns
- Ideal-value: culturally defined virtues, goals, valued conditions and activities
- Deviation: culturally devalued goals, conditions, and types of activity
- Action-norm: normative patterns of social behavior
- Message-form: names of communication media, in a broad sense including art objects and money
- Thought-form: units and styles of reasoning
- Nonspecific objects: abstract references to objects

NATURAL REALM
- Body part: parts of the body
- Natural-object: objects not made by man
- Natural-world: geographical places, weather reference, and cosmic objects

QUALIFIERS
- Sensory reference: smells, colors, tastes, etc.
- Time reference: references to measurement of time
- Quantity reference: references to units and measures of quantity
- Space reference: references to spatial dimensions

PSYCHOLOGICAL PROCESSES

Emotions
- Arousal: states of emotional excitement
- Urge: drive states
- Affection: indicants of close positive interpersonal relationships
- Pleasure: states of gratification
- Distress: states of despair, fear, guilt, shame, grief, failure, or indecision
- Anger: forms of aggressive expression

Thought
- Sense: perceptions and awareness
- Think: cognitive processes
- If: conditional words
- Equal: words denoting similarity
- Not: words denoting negation
- Cause: words denoting a cause-effect relationship

Evaluation
- Good: synonyms for good
- Bad: synonyms for bad
- Ought: words indicating a moral imperative

BEHAVIORAL PROCESSES

Social-emotional actions
- Communicate: processes of transmitting meaning
- Approach: movement toward
- Guide: assistance and positive direction
- Control: limiting action
- Attack: destructive, hostile action
- Avoid: movement away from
- Follow: submissive action

Impersonal actions
- Attempt: goal-directed activity, implying effort
- Work: task activity
- Get: obtaining, achieving action
- Possess: owning, consuming
- Expel: ejecting

Institutional contexts: specification of the social context of rules and actions
- Academic
- Artistic
- Community
- Economic
- Family
- Legal
- Medical
- Military
- Political
- Recreational
- Religious
- Technological

Status connotations: male, female, neuter, and job-role status implications
- Higher status
- Peer status
- Lower status

Psychological themes
- Overstate: emphatic or exaggerated words, generally adjectives or adverbs
- Understate: words, generally adjectives or adverbs, connoting doubt or uncertainty
- Sign-strong: words connoting strength or capacity for action

Sign-weak: words connoting weakness or incapacity for action
Sign-accept: words implying interpersonal acceptance
Sign-reject: words implying interpersonal rejection
Male theme: psychoanalytic symbols of masculinity
Female theme: psychoanalytic symbols of femininity
Sex theme: direct or indirect references to the sex act
Ascend theme: words associated with rising, falling, fire and water, indicating concerns relating to the Icarus complex
Authority theme: words connoting the existence or exercise of authority
Danger theme: words connoting alarm or concern with danger
Death theme: words connoting dying, end

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For further information write Jeanne Spurlock, M.D., Office of Minority Affairs, American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009, or call (202) 232-7878.

The St. Louis Community Homes Program: Graduated Support for Long-Term Care

BY HILARY SANDALL, B.M., B.CH., D.P.M., TIMOTHY T. HAWLEY, AND GLORIA C. GORDON, PH.D.

The authors describe a group-home program that has been operating successfully for three years in St. Louis, Mo. The program offers ex-mental hospital patients the opportunity to gradually acquire experience in living independently in the community. The success of a living arrangement in which an apartment is shared by a group of patients demonstrates that long-term chronic patients can often adjust to minimally supervised living arrangements and that many ex-mental hospital patients can use this experience as a springboard to personal growth and eventual autonomy.

THE DEPARTMENT OF MENTAL HEALTH of the State of Missouri sponsors a group-home program in St. Louis for former state hospital patients. This community homes program provides for semi-independent living in low-rent apartments where tenants may live for a temporary period of time or permanently if they wish. As of March 1975, the program had 52 apartments.

Programs of this type are more common throughout the nation as it is becoming increasingly apparent that persons suffering from long-term mental disorders often do not require the total support provided by institutional settings (1, 2). The St. Louis program is unusual in that it provides a flexible amount of support that is matched to the changing needs of the ex-patients. Disabilities that are produced, in part, by long-term hospitalization are reversed by a gradual reintroduction of everyday responsibilities.

The program was started in 1971 as a pilot project without special funding by several interested staff members at St. Louis State Hospital. After its success was demonstrated, the group-home program became an integral part of the state mental health system. The growth of the program reflects the shifting role of hospital staff as the inpatient census is reduced and a new type of care is provided in a more normal setting. The program opens an average of 2 new apartments a month, a rate of growth necessary to keep up with the steady demand. Patients are referred from outpatient clinics, nursing homes, boarding homes, and foster homes that care for ex-state hospital patients as well as from hospital wards. Private hospitals and agencies also make referrals.

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PROGRAM DEVELOPMENT AND OPERATION

The apartments are located in stable lower- to middle-class areas of the city. Most of the apartments are in buildings called four-family flats, which are owned by private landlords who rent one unit to a small group of ex-patients. Landlords are attracted by the program's reputation for assuring a monthly rent check and a reasonable standard of housekeeping. Our tenants pay the same rent as others in the building and receive no special services from the landlord—important details in their return to normal patterns of everyday life.

A new apartment is usually started by a small group of men or women who knew each other in the hospital. They are asked to choose the area of the city they wish to live in and to help find and furnish their new home. A vacancy in an established group home is filled by inviting a prospective resident to visit for a few days. Members of the household then decide whether or not to invite the new person to join them.

A small nonprofit corporation, Places for People, Inc., was formed in June 1972 to lease the apartments, provide furniture, and aid in the community acceptance of the program. This organization consists of volunteers who work with staff and residents and provide "nonhospital" input.

Tenants pay their rent and other expenses from their income, which is either in the form of wages or public assistance. In 1971 the local welfare department provided ex-patients with a monthly allowance of $80 plus food stamps, based on permanent and total disability assessments. Three or four persons could afford to share the cost of renting an apartment, paying the utility bills, and providing a low-cost but adequate diet. Currently, those who cannot earn a good wage are eligible for a welfare payment of $146 a month because of the addition of Social Security supplemental income. This has improved the participants' basic standard of living. Some residents receive an allowance from the Missouri Department of Vocational Rehabilitation, and others earn enough to support themselves. The program leases apartments with a range of rents that allows for the varying incomes of residents.

The majority of our community homes residents are long-term psychiatric patients. Most of them carry a

diagnosis of schizophrenia, but almost all of the other major psychiatric categories are represented. Screening criteria are deliberately liberal: the only persons excluded are those with a recent history of violence, socially disruptive habits, or thought disorder so gross that it prevents the learning of everyday habits. No age groups are excluded.

The Role of the Staff

Supervision is provided by staff members who visit each apartment regularly and are available to landlords, residents, and residents' families by telephone around the clock. The staff members are part of the community homes team, which consists of a psychiatrist (H.S.), a psychologist (T.T.H.), nurses, aides, social workers, and secretaries. Ten apartments, which house 25 to 35 residents, are visited by one psychiatric aide and one social case worker. These staff members rotate among groups of 10 apartments every three months. Other staff members are involved in the whole program, providing services to all of the residents and supervision to the junior staff. The team meets regularly to discuss policies, new directions, and the division of the increasing workload. Aides and nurses are assigned to the program from the inpatient service of St. Louis State Hospital as the census of the hospitals falls. Some social workers are recruited from among local college and university students who have had practicum experience in the program during their training.

The staff team takes responsibility for supervision of the residents' daily living and psychiatric treatment. Many residents are maintained on long-acting phenothiazines; the use of sedatives is discouraged. All medication is monitored regularly, and adjustments are made when necessary. The high doses given in the hospital can usually be slowly reduced. Residents often take the initiative in regulating their own use of psychotropic drugs. They are encouraged to use local hospitals for medical or surgical services, but if this is not possible for financial reasons they are referred to the medical, surgical, and dental clinics maintained by St. Louis State Hospital.

When a new apartment is opened, staff members help at first with all of the new tasks: planning a budget on a limited income, shopping, cooking, cleaning, going to the laundromat, and other activities of everyday life. As soon as possible, these activities are left to the residents; apartments vary in the degree of autonomy assumed. The decrease in staff involvement, which contrasts markedly with such other forms of extended care as boarding or foster homes, is one measure of the residents' growth of autonomy.

Residents' Activities

All residents are expected to engage in some daily activity. Over half are employed outside of the home, and nearly all take some responsibility for housekeeping. A few, either because of advanced age or low functional capacity, live a semiretired life. Staff or volunteers make sure that the more inactive residents do not slide into apathy and withdrawal.

Groups in some apartments require regular supportive therapy, while others relate to the staff in a more social style. When occasional crises erupt, visiting staff can usually help the group resolve the problem by talking it through and accepting some responsibility for each other. Caring for each other is very strong in some of the groups. They call for help only when a problem becomes intolerable.

Residents usually give a clue to the staff person about the nature of the problem, such as "We think he's not taking his medicine properly" or "Please don't send her back to the hospital, she's only worried because her son is giving her some trouble." Sometimes temporary rehospitalization is required for serious physical or emotional problems.

GROWTH AND CURRENT STATUS

The community homes program has grown steadily since the first apartment was opened in May 1971. As of April 1974, 151 patients had been placed in apartments (see figure 1). Of this total, 87 were in residence during the month of April 1974, although some of these residents left the program during the course of the month and are thus counted twice in figure 1 and in table 1. Residents who left the program since its inception are divided into two groups: the graduates, who moved to more independent living situations, and those who moved back to a place offering more supervision and structure.

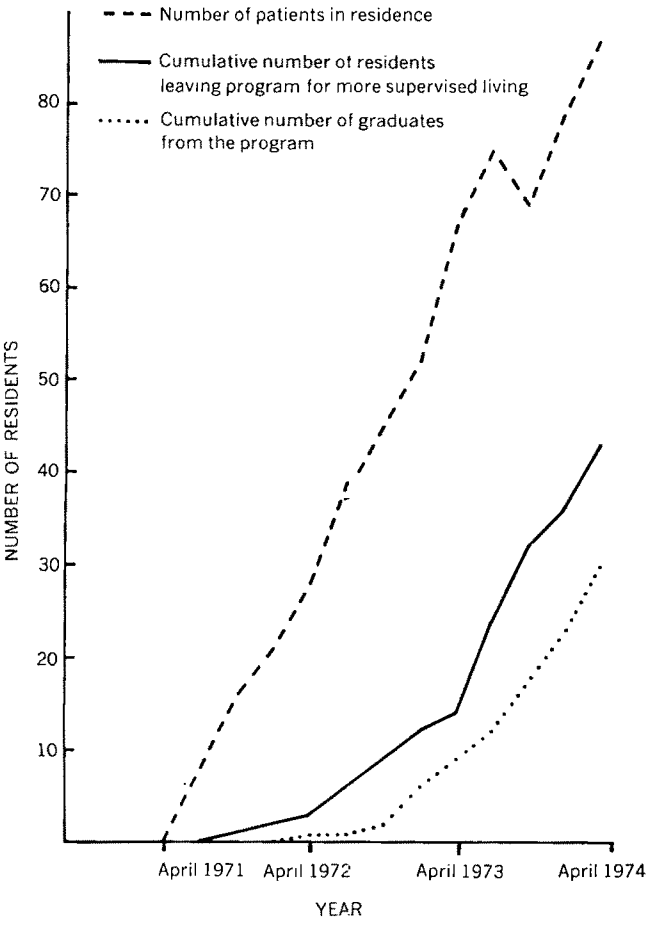
Thirty graduates moved either to places that they rent and manage for themselves, to live-in jobs, or back to their original family. They left the program by their own choice, with staff approval that was based on evidence of sensible money management, regular work habits, and absence of disabling psychiatric symptoms.

The 42 residents who required more supervision moved back to the hospital or to a nursing or boarding home. Some had to move because their physical condition had deteriorated, and others moved because their behavior became unacceptable to their roommates or to the neighborhood. Table 1 shows the number of residents who left the program, grouped according to the reason for leaving and the type of subsequent living arrangement. The length of time that residents spent in the program before leaving does not appear to predict either movement toward more independence or movement to more supervised living.

Problems among roommates can sometimes be resolved by simply moving a resident from one apartment to another. Several persons have made two or more moves before settling down with more compatible roommates in a more congenial neighborhood.

Table 2 summarizes selected demographic characteristics of the total sample of community homes program residents. Age range, sex ratio, distribution of diagnoses, and length of previous hospitalization all reflect the composition of the hospital wards from which the residents were drawn.

FIGURE 1
Yearly Growth of the Community Homes Program



Since chronicity is a commonly cited factor in community readjustment, length of previous hospitalization for community homes program residents is shown in figure 2. Over 100 (about two-thirds) of the residents had been in the hospital for more than 1 year. Thirty had been hospitalized for more than 10 years. One successfully adjusting resident emerged from the wards of St. Louis State Hospital after 41 years of hospitalization.

Table 3 shows a comparison of certain demographic data for those residents who left the community homes program for a more independent living situation with data for those who left the program for more supervised living situations. Age, number of months in the program, length of previous hospitalization, and diagnosis were compared. Only length of previous hospitalization was a significant predictor ($t=2.72$, $df=68$; $p<.01$ by Student's two-tailed t test).

Those residents who returned to a more structured environment tended to be more chronic than those who made an independent adjustment. However, comparison of these two groups of exited residents with residents living in community homes in April 1974 revealed an important result: the length of previous hospitalization of persons living in the community homes environment was almost identical with the length of previous hospitalization of residents leaving the program for a more supervised environment. The current residents have a mean length of previous hospitalization of 90.9 months as opposed to 89.9 months for those who went to more supervised environments ($t=.04$ by Student's two-tailed t test; nonsignificant). Thus, although a shorter length of previous hospitalization predicts a higher probability of becoming a graduate, it does not predict successful adjustment to the program.

TABLE 1
Number of Months of Residence in Program for 151 Residents, by Type of Exit

Item	N	Months in Residence: Range	Mean	SD
Residents who were in residence during April 1974*	87	1–36	13.0	10.67
Residents who went to more independent living situations	31	1–27	7.6	7.48
Residents who went to more supervised living situations				
Psychiatric hospital for behavior problems	16	2–14	6.4	3.26
Psychiatric hospital for more physical care	5	4–24	10.0	9.66
General hospital for more physical care	3	2–4	3.0	1.00
Nursing home for behavior problems	1	—	1.0	—
Nursing home for more physical care	3	9–18	13.0	3.24
Boarding home for behavior problems	6	5–25	12.7	7.17
Boarding home for more physical care	2	5–18	11.5	9.20
Other supervised living situation for behavior problems	5	8–25	15.8	7.26
Residents who died	1	—	6.0	—

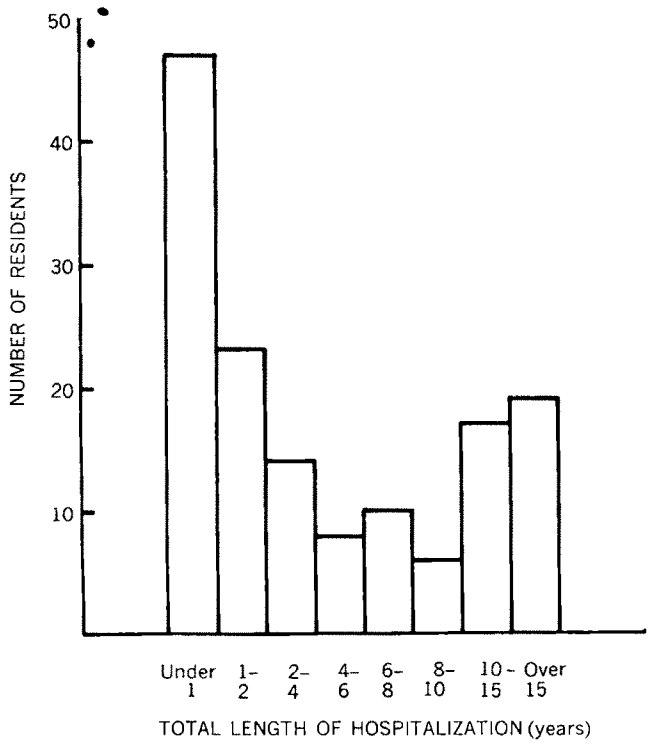
*Some of these residents left the program during the month and are therefore counted twice.

TABLE 2
Selected Demographic Characteristics of 151 Residents in the Program

Item	Number	Percent
Mean age at time of entry into program (range = 18–68 years)	44.50, SD = 12.25	
Sex		
Male	57	38
Female	94	62
Diagnosis		
Schizophrenia	91	60
Organic brain syndrome	15	10
Other*	45	30
Mean length of previous hospitalization, in years (range = no previous hospitalization to over 41 years)	6.50, SD = 8.83	

*This category includes alcoholism, manic-depressive psychosis, various neuroses, and the personality disorders.

FIGURE 2
Total Length of Previous Hospitalization of Program Residents



Although most problems in the community homes program are resolved with the help of sympathetic roommates or staff, occasionally all efforts fail and a person has to be rehospitalized temporarily. Readmission to St. Louis State Hospital can be arranged easily and is followed by reentry into the program whenever feasible. Fourteen residents required temporary rehospitalization during three years of the program's operation. Twelve of these were in residence at the time of rehospitalization, and 2 were former residents. Some subsequently returned to their old apartment, and others found new places with different roommates. A flexible interchange between different levels of care is used in this approach to the long-term treatment of a fluctuating illness.

Activity Ratings

Residents are rated monthly by visiting staff members on five activity level scales—mobility, self-care, vocational activity, social and recreational activity, and housekeeping. Our conceptualization of activity levels stems from work by earlier investigators (3). Table 4 summarizes the activity ratings of the residents of the program during the month of April 1974.

Employment outside of the home is actively encouraged. Local employers, sheltered workshops, and the state's Department of Vocational Rehabilitation assist in this endeavor. Residents in full-time competitive employment are in the final stage before discharge from the program, which will occur when they feel ready to leave. Those in part-time employment may remain in the program indefinitely, unless they move up to competitive jobs.

Most of those who do not work outside of the home are elderly and have little work experience. They are unlikely to leave the program for more independence; eventually they may move to nursing homes.

Social and recreational activity is difficult to assess. Residents at the "normal" level engage in some independent activity outside of the home, such as membership in a chess club, going to a bar or a movie, entertaining friends, and visiting friends or family. Those whose level of social activity is low or moderate are usually new to the program. They still expect visiting staff to guide them and to furnish some form of entertainment. Staff and volunteers provide several social events each month, so that no one sits at home and does nothing.

A high level of housekeeping responsibility is defined as making decisions about spending money on the apartment, keeping the apartment reasonably clean, and requiring minimal help from visiting staff or volunteers. Over half of the residents were at this level in April 1974.

TABLE 3
Comparison of Residents Who Went to More Independent Living Situations with Residents Who Went to More Supervised Living Situations, by Demographic Characteristics

	Demographic Characteristics										
	Age, in Years (range = 18–65)		Number of Months in Program (range = 1–27)		Length of Previous Hospitalization, in Months (range = 0–139)		Diagnosis			Sex	
Item	Mean	SD	Mean	SD	Mean	SD	Schizophrenia N	Organic Brain Syndrome N	Other* N	Male N	Female N
Residents who went to more independent living situations	37.83	13.55	7.23	7.44	26.72	33.04	16	3	11	13	17
Residents who went to more supervised living situations	44.02	13.82	9.07	6.66	89.93	120.48	29	3	10	18	26

*This category includes alcoholism, manic-depressive psychosis, various neuroses, and the personality disorders.

TABLE 4
Activity Ratings of Residents During April 1974 (N=87)

Activity Rating	Number	Percent
Mobility		
Ambulatory with assistance	1	1
Fully ambulatory	86	99
Self-care		
Full self-care	1	1
Full self-care plus care of own bedroom area	86	99
Vocational activity		
None	43	49
Part-time evaluation or training	4	5
Part-time competitive job*	4	5
Part-time sheltered job*	1	1
Part-time sheltered job**	23	26
Full-time competitive job	12	14
Social and recreational activity		
Low level (passive activity)	6	7
Moderate level (mostly within the home)	16	18
Normal level (in both home and community)	65	75
Housekeeping		
None	3	3
Low level of housekeeping assistance	15	17
Moderate level of housekeeping responsibility	21	24
High level of housekeeping responsibility	48	56

*Less than 15 hours a week.
**More than 15 hours a week.

Many of the others were still fairly new to the program and required help from visitors or roommates. Each apartment develops its own style of sharing the regular work. Some are democratic: each person is expected to participate. In others, one person takes over and runs the home. Program staff have very little to do with these arrangements.

A person with high scores on all five activity scales is likely to graduate to more independence. Those with sustained low scores usually move to a more sheltered environment unless they have active roommates who take care of them.

The cost of staff and state hospital services is difficult to estimate with accuracy. During 12 months of the program (May 1973 to April 1974), the staff payroll was $72,500, which averages out to about $725 per resident per year. Overhead, including medication and office expenses, is currently being estimated.

DISCUSSION

As state hospitals increasingly reduce their censuses, living environments for former patients will command greater priority in mental health planning. The community homes concept offers one component of a comprehensive system of living environments that can be adopted by the administrator faced with the task of placing patients in the community. Although some patients need the supervision and structure provided by nursing and boarding homes, many others are capable of living more independently. These patients are done a terrible disservice when they are placed in an environment that reinforces their institutional neuroses and denies them the opportunity for growth toward autonomy.

Choosing the patients who are appropriate to try out this semi-independent living situation is a major concern. In terms of traditional prognostic indicators, many successful community homes residents showed little potential for success. We feel that because the benefits accruing to those who succeed in their adjustment so outweigh the bad effects of possible failure, it is unwise for program staff to be overly cautious in placing patients. Gambles on poor-risk patients can often pay off if the support and supervision are flexible enough to provide increased support in the early stages of resident adjustment as well as more independence when residents show promise of greater autonomy. Failure rarely produces consequences worse than a return to previous levels of care.

State hospitals have traditionally used psychiatric aides to provide housekeeping services and custodial care to long-term patients. Although aides work directly and closely with patients, they often have little influence on methods of treatment: senior aides speak in resigned tones of the new waves that have swept over the hospital, leaving them and hard-core patients virtually undisturbed. In contrast, the community homes program uses psychiatric aides extensively in day-to-day activities. They deliver medication (and know about side effects), train new residents in household skills, supervise the housekeeping as long as necessary, and offer a sympathetic and therapeutic ear in times of crisis.

Some aides have been at the hospital almost as long as the residents. This familiarity is an important factor in helping a resident through the anxieties of adjustment. Like the rest of the staff, the aides rejoice when someone becomes independent and wishes to graduate.

After three years of operation, it has become clear that the program is well accepted by the community. Neighbors of community homes frequently approach program staff, either to offer new apartments or to request help with their own problems. The program is thus a factor in the promotion of neighborhood stability, both economically and in terms of social services. It introduces the concept of caretaking services to neighborhoods whose "regular" residents may be as marginal in their style of life as the ex-patients.

It has also become clear that this method of providing long-term care is less expensive than hospital or nursing home treatment, although reports of similar programs underestimate the actual cost by failing to take into consideration expenses associated with staff, the operation of offices in the community, hospital services, and general program overhead.

The St. Louis Community Homes Program is one of a number of developing programs that attempt to provide alternative living environments for ex-mental hospital patients. The program demonstrates that long-term chronic patients can often adjust to minimally supervised group-living apartments and that many ex-patients can use the community homes experience as a springboard to personal growth and eventual autonomy.

The community homes program can also serve as a model for community placement of ex-mental hospital patients that is inexpensive in terms of tax dollars, relatively simple to operate with usual hospital personnel, and acutely applicable to the problems of the chronic patient. Although the details of operation of the community homes program are in some instances peculiar to the St. Louis metropolitan area, the basic model can be applied anywhere.

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Methadone Maintenance: Some Client Opinions

BY BARRY S. BROWN, PH.D., GLORIA J. BENN, AND DONALD R. JANSEN, M.A.

The authors found similar attitudes toward methadone and methadone treatment programs in 75 detoxification and 115 methadone maintenance clients. Both groups expressed considerable ambivalence—although they viewed methadone as capable of helping them end their heroin addiction, they were concerned about possible methadone dependence and about side effects, both real and imagined. The authors stress the societal context of such concerns and suggest that, although they are not easily allayed, limiting the duration of methadone maintenance from the outset of treatment may be an ameliorative factor.

VIRTUALLY SINCE ITS INTRODUCTION in 1964, methadone maintenance has been both hailed and condemned for its role in the treatment of narcotics addiction. Despite this controversy, the number of people in methadone treatment has risen steadily, and it is estimated that at least 85,000 addict clients in the United States are on methadone maintenance (1).

For these 85,000 individuals, the issues that have been raised regarding methadone's efficacy, safety, and ethics are far from academic. As participants in this treatment, they are not only subject to the benefits and/or dangers attendant on the use of methadone, but they themselves become the subject of controversy. They must contend not only with the need to change their lifestyles but also with community concerns and attitudes toward the treatment techniques used to effect such changes and, by extension, toward them personally.

Findings from studies in the Washington, D.C., community (2–6) have underlined the controversy surrounding the maintenance technique, suggesting both community ambivalence and client concern. Community members describe methadone as permitting individuals to adopt normal lifestyles but at the same time view use of this drug as simply replacing one addiction with another (2). Additionally, addict clients and treatment staff consistently describe the maintenance client as inferior to the abstinent client (3–6). (These studies typically explored only the conceptions of people in treatment programs and compared them with the conceptions of heroin users.) Abstinent clients are consistently seen as less introspective and amiable than maintenance clients but as more actively striving, achieving, and forceful persons. Recent evidence suggests that these attitudes are becoming more fixed (6).

In this context, it becomes essential to explore client beliefs about methadone. These beliefs are obviously relevant to client willingness to enroll in maintenance as opposed to detoxification programs and also to remain in treatment. They therefore impact on treatment outcome. For these reasons, we undertook a study to explore beliefs about methadone as expressed by clients enrolled in several treatment programs.

METHOD

Subjects

During the latter half of 1973, two accidental samples were drawn from client populations enrolled in treatment facilities of the Washington, D.C., Narcotics Treatment Administration, a large urban multimodality addiction treatment agency. One sample consisted of 115 people enrolled in maintenance programs—9 percent of the methadone maintenance clients engaged in treatment at that time. The second sample consisted of 75 people enrolled in detoxification programs, representing 20 percent of the detoxification clients at the time.

The two groups did not differ in terms of age, education, sex, race, marital status, employment, or length of client career. However, they differed significantly from the populations from which they were drawn in that they were more likely to be employed and to have been enrolled in a program for a longer period than other clients.

Procedures

A questionnaire was designed that consisted of 36 true/false items tapping attitudes toward methadone and the methadone maintenance client. The first 13 items were drawn from a questionnaire developed for use in the Washington community (2). We originated the remaining items, many of which were derived from open-ended interviews with clients (conducted by G.B.). We tried to phrase approximately equal numbers of items in positive and in negative terms. Questionnaire items were randomly arranged, with the exception of the first 13 items, which were placed in the order used by Bower (2).

The questionnaires were administered individually and anonymously at clients' treatment sites. Only selected demographic data were requested in association with the paper and pencil tests.

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TABLE 1
Combined Responses of Maintenance and Detoxification Clients to Questionnaire Items, in Percents (N=190)

Item	Agree	Disagree	Don't Know
1. Methadone takes away the craving for heroin.	78.4	19.5	2.1
2. Taking methadone is only replacing one addiction with another.	87.9	8.4	3.7
3. Methadone programs help with the crime problem.	77.4	11.1	11.6
4. Methadone allows ex-addicts to lead a normal life.	57.4	33.7	8.9
5. With methadone you can eventually get off drugs if you want to.	80.0	11.1	8.9
6. Methadone in a treatment program gives you a "high" just like heroin.	24.2	68.9	6.8
7. Once you're on methadone you have to keep taking it.	33.2	60.0	6.8
8. People's reflexes and coordination are not good when they are taking methadone.	34.7	51.1	14.2
9. People who take methadone are just like everybody else except that they take methadone.	60.0	36.3	3.7
10. It's harder to get off methadone than it is to get off heroin.	83.7	11.6	4.7
11. Methadone decreases the sex drive for those who use it.	37.4	51.1	11.6
12. Methadone can rot your bones.	36.3	28.9	34.7
13. You cannot get a drug overdose with methadone.	15.8	79.5	4.7
14. It's harder to concentrate when you're taking methadone.	29.5	60.5	10.0
15. Methadone has done a lot more good for people than bad.	64.2	16.8	18.9
16. The sooner a person stops taking methadone, the better.	84.2	10.0	5.8
17. A reason why methadone has caused problems is because people can get it too easily.	43.7	41.1	15.3
18. Methadone represents an oppression of a black minority by a white majority.	64.7	17.9	17.4
19. A person is better off taking methadone than heroin.	48.4	32.1	19.5
20. The worst thing about methadone is having to take it every day.	43.7	50.5	5.8
21. Methadone will become more of a problem than heroin ever was.	46.8	38.9	14.2
22. Methadone is a safe drug.	14.7	74.2	11.1
23. Methadone is a crutch.	68.4	22.6	8.9
24. The popularity of methadone as a treatment drug is increasing.	55.3	28.4	16.3
25. Methadone can make you sleepy.	75.3	16.3	8.4
26. Methadone is mostly psychologically addicting.	25.3	66.3	8.4
27. There aren't any bad side effects from taking methadone.	10.5	78.9	10.6
28. Methadone has proven to be the best way of quitting heroin.	38.9	45.8	15.3
29. In the long run, methadone is more helpful than harmful.	44.7	27.4	27.9
30. Heroin addiction is worse than methadone addiction.	26.8	62.1	11.1
31. People would not stay off heroin if they didn't take methadone.	31.6	47.4	21.1
32. It's better being abstinent than taking methadone.	61.1	20.0	18.9
33. Methadone programs sometimes act as agents for the police.	48.4	24.2	27.4
34. Methadone is as dangerous as heroin.	77.4	15.8	6.8
35. Methadone has been used more to stop crime than to help addicts.	71.1	17.9	11.1
36. Methadone abuse is happening more and more.	72.6	10.0	17.4

RESULTS

The responses of maintenance clients differed significantly from detoxification clients on only 2 of the 36 items (items 22 and 30, in table 1, $\chi^2=6.62$ and 7.47, respectively, $p<.05$). Since 2 differences out of the total of 36 comparisons could be expected by chance, it was felt that there was not a meaningful difference of opinion between maintenance and detoxification clients regarding methadone and methadone maintenance. Consequently, responses of the two groups are combined in this discussion and in table 1.

There is still some question in respondents' minds about the physical dangers associated with use of methadone. More than three years after the initiation of methadone treatment programs in the District of Columbia, a third of the combined sample still could not decide whether or not methadone rotted bones; another third believed that methadone did, in fact, rot its users' bones. In addition, three-fourths of the respondents reported that methadone can make the user sleepy and produces unpleasant side effects. On the other hand, most clients did not believe methadone decreases sex drive, impairs concentration, or impairs reflexes and coordination, although substantial percentages (30 percent or more) did believe that these effects could occur.

The specter of methadone abuse remains very real for many maintenance and detoxification clients. Substantial majorities of both groups viewed methadone abuse as becoming increasingly prevalent, while a plurality felt methadone created problems because it is too readily available. Indeed, almost half of the clients felt that methadone would become more of a problem than heroin ever was.

Ambivalence about methadone is seen most vividly in clients' beliefs about the drug as a treatment tool. There was widespread agreement (85 percent or more of respondents) that methadone takes away the craving for heroin and helps people free themselves of the use of all drugs over time. Majorities of respondents rejected the concepts that one cannot stop taking methadone and that methadone when used in treatment produces a "high" and agreed that methadone allows clients to lead normal lives, has been more beneficial than harmful to others, and is increasing in public acceptance. At the same time, there was substantial agreement that taking methadone is

using a crutch, that it involves only the replacing of one addiction with another, and that the sooner one quits using methadone the better. Moreover, 46 percent of the respondents disagreed with the statement that methadone has proven to be the best way to quit heroin use.

Subjects indicated a belief that the administration of methadone in maintenance programs serves needs other than the treatment of addiction. Methadone maintenance is viewed as a means of containing crime—respondents agreed that methadone helps with the crime problem and also indicated that it has been used more to stop crime than to help addicts. Moreover, half of the respondents believed maintenance programs sometimes act as agents for the police. Perhaps most strikingly, nearly two-thirds of the clients viewed methadone as representing the oppression of a black minority by a white majority.

We compared our findings with data gathered by the Bureau of Social Science Research in 1973 (1) in response to items 1–13 (see table 1). In that study, the respondents consisted of those 310 adult nonaddict D.C. residents who claimed to be knowledgeable about methadone out of a total of 600 D.C. residents sampled. No effort was made to obtain comparability between the nonaddict D.C. residents and addict clients on demographic measures.

The two groups differed markedly in their thinking about methadone. Knowledgeable nonaddict D.C. residents were less likely to give an opinion regarding methadone, selecting the "don't know" category significantly more often than addict clients on 8 of the 13 items. Nonaddicts also differed from addict clients in their agreement/disagreement with 6 of the 13 items (items 5, 6, 8, 9, 10, and 12 in table 1). Addict clients were significantly more likely than community residents to view methadone as permitting the individual to free himself of drug dependence while seeing methadone clients as no different than other persons and feeling that methadone properly administered does not give a high. However, addict clients agreed that it is harder to get off methadone than heroin to a significantly greater extent than did the nonaddicts. Finally (and inexplicably) addict clients were significantly more likely than nonaddicts to believe that methadone did not impair reflexes and coordination, but did rot its users' bones. There was no difference in level of agreement with the statement "Methadone programs help with the crime problem" between the two groups.

DISCUSSION

Clearly, and not surprisingly, the ambivalence about methadone maintenance that seems to prevail among the general public is reflected among clients in both detoxification and maintenance programs. In the client's view, methadone's usefulness as a treatment technique is undeniable, but it remains a suspect drug.

The use of methadone is viewed by clients as involving dangers that are both realistic (e.g., the threat of overdose) and unrealistic (e.g., rotting of the bones). Moreover, methadone maintenance is seen by addict clients as an effective means for quitting heroin but one that must be rejected as anything other than a short-term solution because it involves the same encouragement of dependency as heroin does.

However, the suspicions of addict clients regarding the technique of methadone maintenance emerge most strikingly in terms of the motivations they ascribe to society. Not only are maintenance programs seen as being more involved in crime fighting than in helping people, they are considered by many to be acting on behalf of the police and even as a part of a system of oppression of blacks by whites.

It appears that clients' ambivalence about methadone and maintenance techniques must be viewed in terms of their concerns regarding the motives of the larger (i.e., middle-class and white) population. The client population we studied, like client populations throughout the country, is composed primarily of minority group members (more than 90 percent black). In a time when heightened awareness of minority group status is encouraged if not demanded, black addict clients are likely to be concerned with the extent to which they are in agreement, and can show themselves in agreement, with individuals in the community they identify as significant. This demonstration of shared values and beliefs is far more critical with issues that become politicized and are therefore more likely to be seen as requiring community consensus (i.e., those which impact more heavily on the minority than on the majority group and/or appear to contain the stuff of racial confrontation). The use of methadone in maintenance regimens appears to be such an issue.

The problem of heroin addiction is disproportionately visited on nonwhites, but the methadone maintenance solution carries the stamp "made in white America." Methadone is seen as something that white Americans do to/for nonwhite Americans. Concerns related to efficacy, safety, and ethics must be seen in this context. It seems safe to say that methadone can never gain acceptance on the basis of scientifically demonstrated merit alone. To gain acceptance with the consumer (addict) community, methadone must overcome or circumvent the hostility and suspiciousness that often characterize white/nonwhite relations—particularly within the consumer's socioeconomic class. A study by Averbach and Walker (7) suggested that black trust in governmental institutions and operations has dropped precipitously during the past five years. It is likely that these attitudes also play a role in distrust of methadone and of the typically government-supported methadone maintenance programs.

The dilemma for the addict client seeking assistance is considerable. If he (and a large part of his community) views methadone as serving societal needs for control—if not repression—while at the same time seeing it as serving his need to overcome dependence on a debilitating substance, ambivalence toward methadone seems inevitable.

While this ambivalence is seen from the outset of the client's entry into treatment (8), there is good reason to believe that addicts' concerns about methadone do not

prevent their seeking treatment from programs offering maintenance regimens alone or in combination with other treatment forms—available treatment slots are easily filled. One survey found that the inability to see oneself as having a heroin problem and residential isolation from treatment programs rather than concern about methadone were cited by first-time addict clients as the major reasons for their not having entered treatment earlier (9). When the addict recognizes and is concerned about heroin dependence, his problems are too intense for ideological considerations. There is the clinic, the street, the jail, or the morgue. In that context the clinic becomes at least an acceptable alternative.

It is probable that attitudes ascribed to the community and the client's own concerns regarding methadone can begin to be felt only after the client is inducted into treatment and can feel himself gaining control over his heroin problem. The danger for both client and community at this time is that the client will feel impelled to separate himself from the methadone dispensers before he has made a significant change in his life functioning. Some support is provided for this hypothesis by the earlier study (3) in which methadone clients were asked to estimate upon entrance into treatment and one month later the length of time they expected to remain in treatment. Clients significantly decreased their estimates after the initial month of treatment (3). There was also a significant and positive correlation between estimated and actual treatment time.

The dilemma for both client and community is obvious. A treatment of demonstrated usefulness is fraught with concerns that range far from the field of treatment, concerns that hinder easy acceptance or prolonged reliance on methadone in stabilization regimens. Perhaps some partial resolution lies in the design of time-limited maintenance programs that permit the client to feel that he is freeing himself of methadone as he achieves certain behavioral objectives that are necessary to his effective functioning (e.g., a stable home situation, a legitimate source of income, etc.).

It seems clear that clients' reservations about methadone are rooted in issues and concerns that do not permit easy modification. Indeed, the objective to be sought is not community support for stabilization techniques, but rather sufficient community tolerance to permit clients to remain in treatment long enough for them to obtain the tools necessary to explore alternatives to the addict lifestyle. It is suggested that client reservations about the treatment modality be recognized in treatment and dealt with through the use of techniques that allow the client to see an end to his reliance on methadone from the time of his entrance into treatment.

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Is Everyone Depressed?

BY ROBERT A. WOODRUFF, JR., M.D., PAULA J. CLAYTON, M.D., AND SAMUEL B. GUZE, M.D.

The authors collected a large number of research interviews with relatives of patients from a psychiatric research clinic. Half of these patients were clinically depressed; their relatives as well as the rest of the relatives interviewed were therefore at high risk for depression. However, few of the relatives reported memorable dysphoria or any clustered episodes of other affective symptoms. The authors conclude from these data that, contrary to the opinions expressed by some, not everyone has episodes of depression. Everybody is not *depressed.*

ARE WE ALL psychiatrically sick—some only slightly, others quite a bit? Do most men "lead lives of quiet desperation," as Thoreau stated, and is this reflected not merely by frustration with the world and its problems but by actual symptoms such as the kind we call psychiatric-depressive symptoms?

Individuals who have been depressed may find it hard to imagine the possibility that many persons do not intensely experience the same thing. Psychiatrists who watch an endless parade of patients may also think so. A well-publicized study of the 1960s (1) suggested that somehow most of us are psychiatrically ill. The traditional view that psychiatric health and illness are on a continuum is compatible with that idea.

Depression, along with its associated symptoms, can serve as a yardstick because it is common; it is probably the single most frequent problem with which psychiatrists deal. Studies from our own psychiatric clinic (2, 3) indicate that affective disorder is the chief reason for patient visits and that even patients with other disorders such as anxiety neurosis or alcoholism often seek psychiatric care because of associated depressive symptoms. One could think that nearly everyone must have had memorable episodes of dysphoria, whether or not they have been psychiatric patients. Finding that we had data that allowed us to investigate this hypothesis, we conducted the following study.

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METHOD

Between 1967 and 1969 we collected a random sample of 500 patients from our psychiatric clinic. They were the starting point for follow-up and family investigations still in progress. The studies are conducted blindly in that follow-up interviews and interviews with relatives are conducted by persons who have no knowledge of index interviews or diagnoses. Further, we will not break the code associating probands with follow-up interviews or with their relatives until the study is completed.

At this point we have over 900 research interviews with relatives. Diagnoses were made among the relatives according to research criteria similar to those reported elsewhere (4). The specific diagnostic criteria for affective disorder are illustrated in appendix 1. Only the criteria for depression are given because mania is not a subject of this presentation.

RESULTS

Of the 900 relatives interviewed so far, 495 (55 percent) were judged to have no psychiatric illness.

The papers in this section are grouped around a specific topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.

Ninety of the 900 relatives (10 percent) were given a diagnosis of either primary or secondary affective disorder. Sixty-two subjects had probable or definite primary affective disorder, and 28 subjects had probable or definite secondary affective disorder. In addition, there were 37 subjects with "undiagnosed psychiatric illness—probable depression." These relatives had had one or more episodes of severe dysphoria with several other affective symptoms (usually three symptoms); they were not given a diagnosis of depression only because they fell short of our criteria for affective disorder. Thus 127 of the 900 relatives (14 percent) had definite, probable, or possible affective disorder.

Of the 495 psychiatrically well relatives, 365 (74 percent) were never memorably dysphoric, i.e., for longer than a few days. These subjects did not report ever having other affective symptoms. Seventy-eight additional healthy relatives (bringing the total to 89 percent) were free of memorable dysphoria but did report other occasional affective symptoms.

DISCUSSION

That three-fourths of the relatives who had no definable psychiatric illness reported neither memorable dysphoria nor clustered episodes of other affective symptoms is a clear indication that not everyone has periods of depression. We would expect this sample (relatives of psychiatric patients) to demonstrate widespread dysphoria if any would. They were not chosen at random from the general population; rather, they were first-degree relatives of psychiatric patients, half of whom had been clinically depressed. Whatever genetic predisposition may exist for affective disorder, these relatives were at high risk. Whatever social or environmental sources of predisposition may exist, these relatives were again at high risk.

Regardless of our preconceptions, it seems unquestionable that a large number of persons lead relatively unruffled affective lives. Affective disorder is common, but that does not mean that everybody has a bit of it. It would appear that although depression is common, freedom from memorable dysphoria is even more common. If "the mass of men lead lives of quiet desperation," that despair is to be seen as philosophical, economic, or existential—not psychiatric in our sense. We believe the distinction is important and that failure to appreciate it has been a constant source of confusion for psychiatrists.

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APPENDIX 1
Criteria for Affective Disorder

A. Dysphoric mood characterized by any of the following: depressed, sad, low, blue, despondent, hopeless, gloomy, disgusted, discouraged, empty, "don't care," worried

B. Definite, five of the following eight criteria; probable, four out of the eight:
   1. fatigue or loss of energy
   2. loss of weight or appetite
   3. loss of general interest or sexual interest
   4. insomnia or hypersomnia
   5. thoughts slowed or mixed up or trouble concentrating
   6. thoughts of self-reproach or guilt
   7. thoughts of death or suicide
   8. agitation or retardation

Primary affective disorder and secondary affective disorder are distinguished by the chronology of a subject's history. A depression beginning after the onset of another psychiatric illness is considered secondary. The terms "primary" and "secondary" have no etiological connotation.

Depression: Schism in Contemporary Psychiatry

BY ANTHONY M. D'AGOSTINO, M.D.

The author describes an experience in his own family involving the initial unsuccessful treatment of a depressed patient. The patient failed to respond to psychotherapeutic and drug treatment on an outpatient basis and in three hospitals; in a fourth hospital he improved dramatically after a series of ECT treatments and remained without depressive symptoms. The author stresses the importance of psychiatrists keeping an open mind about various treatment approaches.

AS A MANIFESTATION of the state of any relatively inexact science, there exists in psychiatry a variety of treatments for almost every known disorder. Depression is, of course, no exception; one can suppose that until more exacting standards are developed there is merit in the competition of various approaches with, presumably, the more successful treatments eventually prevailing and the less successful methods falling by the wayside.

The problem, however, is much more complex, and such optimism may not be wholly warranted. For one thing, the various schools of thought are not in the habit of comparing their treatment approaches objectively with any other. Problems of definition arise, and there are serious difficulties associated with trying to get everyone to agree on a terminology, especially when one is speaking of depression. Certainly a question like "Have you ever felt depressed?" would elicit an affirmative response from almost everyone. It is with this in mind that since the time of Hippocrates, and probably earlier, physicians have attempted to organize apparently related symptoms into syndromes and, where possible, into specific disease entities, the goal being the development of the most parsimonious form of therapy.

Unfortunately, in the mid-1970s we are still unable to agree on whether depression is a disease, a scapegoat phenomenon, a problem in living, a conditioned response to a series of more or less accidental environmental contingencies, an overly insightful existential awareness of the futility of man's struggle against the inevitability of death, or all of the above.

The following is the history of a depression of the so-called involutional type and the efforts of one family to do something about it. Despite the limitations of the single case history presentation, I feel this case may merit reporting since it illustrates not only the variety of mental health services and techniques available to a consuming public but also the reaction of one professional who, at the beginning of his training, was able to experience on a very personal level the schism in points of view in contemporary psychiatry. I am the professional; the patient is my father.

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THE PROBLEM

I was 24 years old and had just graduated from medical school. My father was as I had always known him—low-keyed, sociable, more than a little pleased at his only son's graduation to doctorhood. He was also near the bottom of my list of potential mental patients—much too steady, too reliable, no history of anything save essential hypertension diagnosed a year earlier and well-controlled on a fixed combination drug of 0.1 mg of reserpine, 25 mg of hydralazine hydrochloride, and 15 mg of hydrochlorothiazide (Ser-Ap-Es). Seven days after graduating I left my home state to do a one-year internship. Sometime during that 12-month period a radical change occurred in my father's state of mind.

His appearance had changed dramatically. He was 52 but looked 70; he had lost over 20 pounds and was anxious and agitated. He would ruminate over what he felt were occasions of bad judgment on his part. Worst of all, he could barely get himself to work in the morning. He "knew" he wasn't doing his job properly and felt his employer was keeping him on only because the others in his department were covering for his ineptitude. He would awaken early in the morning and debate with himself (and my mother) over how he was to face another day on the job. Believing that his performance on the job was his problem, my mother called his employer. She was even more perplexed when she was told he was functioning as well as ever, although he seemed worried and less interested in the social aspects of his work.

In addition, he seemed more self-centered than I'd ever known him. He talked only of himself, his failures, and his bleak future. Friends and relatives would come over to cheer him up and leave many hours later, frustrated by what seemed his unreasonableness and inability to make a decision. Normally compulsive, he became a caricature in the extreme. When I finally decided that some kind of treatment was definitely indicated, he would not hear of it. Angry at what I felt was an incessant repetition of the same issues with no conclusions, I found more and more reasons not to visit my parents. I had my own patients to worry about and did not need another. Moreover, I knew

that he would probably be a miserable candidate for psychotherapy. After an abortive attempt at office psychotherapy, hospitalization was recommended.

We sought admission to what I felt was the best available psychiatric hospital. As it turned out, however, there were no beds available at the time and an alternate was suggested. Since a crisis of sorts had developed by this time, I thought it wise to take what was available; the alternate institution had been well recommended. From my point of view as both a first-year resident and a consumer of psychiatric services, the experience proved a little puzzling.

HOSPITAL A

After much hassling, my father and I arrived at the hospital. He was seen by a psychiatrist who seemed to agree that he needed hospitalization. However, in speaking to me afterward, he expressed an opinion that the process had been going on and/or developing for many years. I was distressed that somehow I had not been able to see it since I thought the illness had developed during my one-year absence. My comments to that effect didn't seem to change anything, but I was hopeful that now some meaningful treatment might occur.

The hospitalization lasted only eight days. The final diagnosis was "chronic brain syndrome" and the reason for discharge at that time was "patient refuses psychotherapy." Even more painful was the recommendation resulting from the inpatient evaluation—custodial-type care at home (i.e., no more employment, at least not what he had been doing, early retirement [age 53], and application for Social Security benefits as a means of support). The psychiatrist's fee for this evaluation was by far the most expensive item during the course of the entire illness, considering the length of the hospitalization.

HOSPITAL B

Even I could realize that something wasn't right at hospital A. My father's condition had stabilized somewhere around absolute zero and the agitation and ruminations continued. Meanwhile, beds became available at the hospital originally chosen. Like hospital A, hospital B was generally known for its use of a model similar to the one used at the institution where I was serving my residency (many of our faculty also served on the faculty of the training program at hospital B).

I can vividly remember my feelings of shame and nagging responsibility as my father was admitted for the second time to a mental hospital. After 10 months of a psychiatric residency, I was well aware of the importance of intrafamilial dynamics in the etiology of mental illness and resolved that somehow this treatment was going to go forward. I would do my best not to let anxiety, guilt, shame, or resistance get in the way.

The psychiatrist during this hospitalization seemed to have a much better idea of what my father was dealing with, and from the kinds of things my father talked about during visits I surmised that his psychiatrist was devoting considerable time and energies to helping him cope with his illness. I agreed with his techniques, which involved a combination of medication and psychotherapy—exactly what I was involved in with my own patients, depressed or otherwise. But there was to be another problem—my mother.

Despite the efforts of his physician, my father was not impressed. In fact, he felt he was being "tortured." He would impart these impressions daily to my impatient mother who, after my father had been hospitalized for two months, was beginning to feel that the illness would never end. She also became paranoid about the psychiatrist, who would say very little when she called him to get information on how things were progressing, obviously giving her a chance to say what was on her mind. Since I was using essentially the same techniques with my patients, I had little difficulty understanding the rationale. With my mother it was quite another story, and feeling put off, she finally agreed with my father that hospitalization was not the way to go and took him home over my objections. This action filled me with despair, both because I felt that without treatment this could go on indefinitely and because it had become plain that my father was not a "good" treatment case, i.e., not psychologically minded, and my mother was being uncooperative.

At this point it appeared that we would now carry out essentially the recommendation of the psychiatrist from hospital A. Social Security benefits were applied for and received and the family seemed to accept the inevitability of caring for a casualty from life. Only his incessant complaints and disturbing agitation forced us into trying once more to get treatment.

During one of her phone conversations with the psychiatrist from hospital B, my mother was told that illnesses of this type often lasted as long as two years. During a visit she met one patient, about my father's age, who had been in the hospital for over a year. The cost of such a stint with no guarantees of success had something to do with why my mother was inclined to go along with my father's complaints about the hospital.

HOSPITAL C

I thought that a different approach might be helpful. Hospital C was a publicly supported institution of good reputation staffed with personnel inclined toward avant-garde psychiatric treatment. It was less expensive than hospital A or B and was strongly influenced by principles growing out of the community mental health movement. My own residency program, although strongly psychoanalytic, had taken a number of significant steps in the direction of a more community-oriented approach to mental health services. Our faculty contained several dynamic proponents of the community approach who felt that mental health was not so much an individual as a

group phenomenon. By this time I was a second-year resident.

It was a struggle, but we arrived at the appointed time. We were met by an intake team consisting of a psychiatric resident, a social worker, and (I believe) a psychiatric nurse. Father was interviewed by the psychiatrist, my mother and I were interviewed by the others. By this time, I had the story down pat, feeling that my father's emotional condition was appalling; however, my father was well dressed, sitting up, and minimizing his problems. After the interviews the team conferred and gave a verdict: day hospital.

I was disappointed but tried not to show it. My mother's disappointment was obvious. It had taken several hours of hassling to get him out of the house and into the car for the appointment; could we do it five days a week? Would the family be cooperative? The team had mentioned that if he was not "motivated" he could not be helped. Although my father had agreed reluctantly to start the following day, when the time came he wasn't motivated; he never went to the day hospital. His symptoms continued.

By this time, my mother and I were not getting along too well. After all, I was studying to be a psychiatrist and should be able to do something for my own father. I tried to explain that these things took time, pointing out that she had an excellent doctor at hospital B and had pulled Father out prematurely. We returned to hospital B, and after another month the same problems were there, with no improvement.

HOSPITAL D

Finally, my mother took matters into her own hands. Living in a small, lower-middle-class suburb, she took Father to see a psychiatrist practicing in the town. He saw Father for a few minutes and recommended hospitalization and electroconvulsive therapy. He even went so far as to suggest that my father's antihypertensive drug might have been implicated in his illness. By this time, my mother and I were speaking again. Since I had been less than helpful up to this point, I kept out of the way. Nevertheless, I had read Hollingshead and Redlich and knew that the less affluent often got more cursory "medical" (by implication, less effective) treatment.

I would like to mention something about ECT at this juncture. My training up to this point had led me to believe that electroconvulsive therapy was a thing of the past and was still used only by people who didn't know that the millenium had arrived. Psychotherapy and "therapeutic community" were in; ECT was definitely out. Of about 100 admissions to our unit during my first year of residency, only one patient (mine) received ECT, and the treatments had to be stopped after three sessions because the patient was a black man and the staff wondered whether I wasn't simply torturing an already sufficiently oppressed citizen. The patient, hospitalized for seven months, was both schizophrenic and depressed; after three ECT sessions, he felt better and went home. Nevertheless, convinced that there is no room for ECT in a therapeutic milieu, I wondered if it wasn't true that I had viewed the patient as a lesser human, deserving of such tortures. Four months later I was acquiescing to my own father being so treated, with the sanction of my unenlightened mother, in a hospital of marginal repute.

Six weeks later my father was again working, and if the word "cure" can ever be used in psychiatry, it could be used in his case. He saw his psychiatrist only once afterward and the long nightmare was over—no insight, no awareness, no motivation to get well. There remains no evidence of depression or any other illness.[1]

DISCUSSION

One hears a good deal these days about the relevance of the so-called "medical model" in psychiatry. As a practicing psychiatrist-psychotherapist, I have on many occasions had reason to question the usefulness of much psychiatric nosology. Nevertheless, one must wonder why it is that techniques of psychiatric treatment with rather obvious usefulness can be allowed to go unused and untaught. For some reason, if one attempts to understand a patient's sufferings in psychodynamic terms this somehow precludes using medical therapies, although the converse also often applies. ECT was not merely untaught during my residency training, it was actually disparaged and looked upon as an assault on one's patient for which the good psychiatrist should feel guilty and initiate in himself some powerful soul searching. In psychiatry the "good" patient is one who understands the origins of his illness, not, as in the rest of medicine, one who thrives on the therapy of his physician. Those who do improve on somatic therapies like ECT are said to be guilt-laden people who want to be assaulted to expiate their guilt.

Diagnosis is also grist for the therapeutic homogenizer. The impression is that all people develop mental illnesses for basically the same reasons; therefore, the treatment of mental illnesses involves variations on the same basic techniques. Some psychiatrists treat all patients on the couch. In these cases the determination of whether or not a patient is suitable for such treatment rests on how psychologically minded a patient is rather than on whether the process is suitable for verbal psychotherapy. In these cases also the diagnostic process attends primarily to the relationships between mental structures (i.e., id, ego, superego) or the affects, rather than to the descriptive, syndrome-oriented, or disease model, as if disease in the medical sense does not exist in psychiatry.

On the other hand, we have all been critical of the converse approach: the psychiatrist who electrifies and/or drugs any and all patients who present themselves for treatment, whether they suffer from schizophrenia, de-

[1]After receiving ECT, my father was also taken off his antihypertensive medication. Reserpine depletes brain norepinephrine and may cause depression. It is not known whether the withdrawal of reserpine contributed to my father's recovery.

pression, homosexuality, or marital maladjustment. These physicians seem to equate "different" with "sick," and no doubt serious injustices in the form of insensitive treatment, forced confinement, and the nefarious "labeling" have occurred. Nevertheless, and this is especially true in many state-operated and community facilities today, it is as if mental illness, as illness, does not exist, and use of medical therapies such as ECT is disparaged and simply not available to patients. Diagnosis is deemed irrelevant just at a time when logic dictates that it is more important than it has ever been.

From the point of view of the layman, who comprises the majority of patients, the schism that I have described can only appear as further evidence that psychiatrists have little to contribute to the well-being of society.

The pernicious consequences of one's choice of treatment were highlighted several years ago when a high government official was denied a chance for even higher office by virtue of the treatment he had accepted for an alleged depressive episode. Because he had received ECT, his fitness for high office was suddenly in question. Had he had the same symptoms but been treated with psychotherapy, plus or minus medication, his chances might have been different. Unfortunately, too many psychiatrists trained to believe that ECT has few indications and then only for the "very ill" are unable or unwilling to properly inform a public which still looks upon ECT as a form of electrical purgatory or last-ditch radical treatment for the virtually hopeless.

In my own training I can vividly recall looking for an appropriate candidate for ECT only to have every candidate rejected as "not that ill." I am certain that had my father been admitted to my residency training program, he would not have been considered ill enough to receive ECT. Even if he had been so considered, the issue would never have been raised out of deference to me.

COMMENT

In this presentation of the history of my father's mental illness and my family's attempts to get treatment, an effort has been made to highlight the consequences of the obvious lack of communication among various schools of psychiatry. It has not been my intention to denigrate anyone's approach but rather to point out that we have much to learn from one another in dealing with the problems our patients present to us.

Electroconvulsive Therapy for Chronic Pain Associated with Depression

BY MICHEL R. MANDEL, M.D.

Electroconvulsive therapy alleviated the symptoms of four out of six patients suffering from chronic pain and from depression as measured by the Hamilton Depression Rating Scale. All of the patients had been unsuccessfully treated with tricyclic antidepressant medication. The author suggests that ECT may be the treatment of choice for some patients with this combination of symptoms.

AMONG THE MOST DIFFICULT patients to treat in medical practice are those who present with pain problems requiring a subtle differentiation between predominantly physiologic pain and psychogenic pain. The histories of these patients often read like odysseys, with multiple hospitalizations, clinical procedures, and physician contact. Engel (1) has described this group of patients as "pain prone." Frequently they are not psychologically oriented people, in fact, just the opposite, and they often reject attempts to obtain psychiatric consultation. It has been shown that the presentation of the painful symptom is influenced by the patient's individual personality and other variables, including cultural background, suggestability, and various types of stress (2). There is often a strong suggestion that this group of patients has long-term psychological difficulties (3).

Various contributing factors maintain the symptom complex in chronic pain syndrome, including malingering, hypochondriasis, and conversion reaction (1, 4, 5). Several authors have shown that depression can also play an important role in pain and that affective disorders sometimes accompany other diagnoses such as conversion reaction (1, 4). Ziegler and associates (6) reviewed the cases of 100 randomly chosen patients with a

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primary diagnosis of depression and found that 28 demonstrated conversion symptoms of pain. The mean age of this group was 46.5 years.

TREATMENT

The presence of affective symptoms is often a good prognostic sign in psychiatric illness, especially if they are acute, and it would seem reasonable to attempt to separate out a depressed subgroup of chronic-pain patients for antidepressant therapy. This is particularly true since with the introduction of electroconvulsive therapy in the 1940s and monoamine oxidase inhibitors and tricyclic antidepressants in the middle 1950s, many depressions have been rendered treatable (7).

Various investigators, particularly in the British literature, have described their varying success in treating chronic-pain patients with mood-altering drugs such as antidepressants, phenothiazines, and antihistamines (4, 8). In general, it has not been possible to precisely identify this group on the basis of psychological factors such as depression. It is not known what percentage of depressed chronic-pain patients respond to antidepressants, but I have found that many of them do not experience symptom relief with this therapy.

ECT has had varying degrees of success in the treatment of patients with chronic pain (9–11). A MEDLARS (Medical Literature Analysis and Retrieval System) computer search of the world literature for the past 20 years revealed only a few articles relating to the efficacy of ECT in this group of patients (9–12). In one of the most recent reports, which was published in 1957, Von Hagen (10) reported on 8 patients with intractable pain and extensive histories of pain. All of his patients did well, and although their psychiatric histories were not extensive, depression was mentioned in 6 of them. Weinstein and associates (11) selected 10 patients with long-standing pain from the neurological ward of a general hospital and found that there was no essential change in their perception of pain beyond the period of delirium induced by bilateral ECT. These researchers concluded that ECT was not a feasible method for the relief of intractable pain. They did not mention whether these patients also suffered from depression. Bradley (12) has suggested that the coincident onset of pain and depression is associated with the relief of pain when the depression is treated with ECT.

This paper reports on a study of 6 patients with chronic pain who had failed to respond to tricyclic antidepressant therapy. These patients were considered clinically depressed and received a series of ECT in the course of their clinical care.

THE PATIENT SAMPLE

Index scores on the Hamilton Depression Rating Scale (13) were obtained for a group of chronic-pain patients at Massachusetts General Hospital who were judged to be clinically depressed and were undergoing clinical evaluation for further treatment. Six patients with scores higher than 20—indicating at least moderate depression—were selected for the study.

The patients consisted of 1 man and 5 women, ranging in age from 47 to 73 (median age = 54.5 years). All had undergone extensive neurological and medical diagnostic procedures, and a significant physiological basis for their pain had been eliminated. The duration of pain varied from 6 months to 30 years. In five of the six cases, the pain became more intense and was associated with depressive symptoms over a 6- to 24-month period prior to consultation. In most of the patients, significant psychological themes of secondary gain could be identified, and there were often conflicts within their nuclear families vis-à-vis such issues as dependency and aggression. Five of the 6 patients could not be considered psychotic unless the pain symptoms themselves could be called delusional. One patient (case 3) was eventually diagnosed as psychotically depressed.

The pains included backache, atypical facial pain, headache, and chest pain. All of the patients could be considered addicted to various narcotics at some time during their treatment for pain; 4 were addicted at the time of consultation. All of the patients had been treated with tricyclic antidepressants; this therapy was unsuccessful despite the fact that adequate amounts of drugs had been prescribed (dosage trials were the equivalent of 200 to 250 mg of imipramine daily). Three patients denied feeling depressed, and the 3 who did identified depression as a secondary symptom. None of the patients could be considered manic-depressive or suffering from primary affective disorder. All of them met the criteria for secondary affective disorder established by Feighner, Robins, and associates (14).

The patients received nondominant hemispheric unilateral ECT 3 times per week. The procedure was modified by atropine, methohexital, and succinylcholine anesthesia. Four patients demonstrated a remarkable improvement in pain and depression. Clinical data on the sample are presented in table 1.

CASE REPORTS

Responders

Case 1. A 47-year-old contractor had experienced intense headaches in the left temporal area for 5 years; he said they felt as if "someone had quartered my head." The pain first occurred in the context of the birth of an illegitimate grandson and his son's subsequent marriage and rapid annulment of the marriage, with the son and grandchild eventually coming to live in the patient's household. The patient, who blamed himself for his family's misfortune, did not feel that he could protest or complain about his son because of his own history of severe alcoholism, which had persisted until he joined Alcoholics Anonymous 10 years prior to his admission. The patient's headache and his emotional withdrawal occurred intermittently and particularly at times of unavoidable argument with his son and wife. His internist treated him with various analgesics, including up to 8 tablets daily of a semisynthetic narcotic analgesic (Percodan)

TABLE 1
Clinical Characteristics of Six Patients with Chronic Pain and Depression

Patient	Sex	Marital Status	Age	Location of Pain	Duration of Pain		Comfortable During Observation	Hamilton Score		Subjectively Depressed	Personality Diagnosis
					Overall	Acute		Pre-ECT	Post-ECT		
Responders											
1	M	Married	47	Head	5 years	0	No	40	3	Yes	Passive-dependent, mild
2	F	Married	55	Head	20 years	2 years	Intermittently so	26	14	No	Passive-dependent, mild
3	F	Single	64	Chest	10 months	10 months	No	59	5	Yes	Mixed, with passive-aggressive and hysterical elements, moderate to severe
4	F	Married	52	Back, face, head, chest	6 months	6 months	No	53	11	Yes	Hysterical personality, moderate
Nonresponders											
5	F	Married	73	Face	20 years	2 years	Intermittently so	32	19	No	Hysterical personality, moderate to severe
6	F	Married	68	Face, head	30 years	2 years	Yes	25	22	No	Passive-aggressive elements, moderate to severe

and antidepressant medication. He was hospitalized because of addiction to the analgesic and decreasing work performance.

Mental status examination revealed a depressed man with sad facies, stooped posture, and slow speech. He constantly referred to his headaches and appealed to the examiner for some medication. He admitted to symptoms of depression only during specific questioning. He scored 40 on the Hamilton depression scale.

Following a series of 6 unilateral ECTs, the patient's headache disappeared and his Hamilton score fell to essentially zero. On 2 occasions in the year of follow-up he has become subjectively depressed and has been given a 6-week course of 150 mg of doxepin at bedtime. He has not missed a day of work since his discharge from the hospital, and his headaches have not recurred.

Case 2. A 55-year-old married mother of two and wife of a salesman had complained intermittently for 20 years of "migraine" headache, which was relieved somewhat by ergotamine tartrate and caffeine (Cafergot) and a semisynthetic narcotic analgesic (Percodan). She stated that she also needed amphetamines not only to reduce her pain but to "get me going," and she had used them intermittently for almost 20 years. She had lived near her family for her entire life until 2 years prior to admission, and her hospitalization was triggered in part by her move to a new location about 200 miles away from her previous home, as well as by the Food and Drug Administration's more stringent control of amphetamines, which made it difficult for her to obtain them. Her internist, noting that she appeared depressed, treated her with up to 250 mg of amitriptyline, at bedtime, for several months prior to ECT; there was no change in her symptomatology.

During her mental status examination she was extremely reluctant to talk to the examiner and insisted that the lights be turned off during the interview because they exacerbated her "migraine." When she did talk, she spoke of missing her previous home and her "pep pills," and she complained that her husband was away much of the time—yet denied being the type who would complain. Despite an elevated Hamilton score of 26, the patient denied being depressed and was only able to talk about her depression once ECT had begun. After 6 unilateral ECTs her mood brightened and her headache disappeared. At 6-month follow-up her Hamilton score was 14, she was up and around, her husband reported that she was strikingly improved, and she reported no recurrence of pain.

Case 3. A 64-year-old single woman was seen in consultation on a psychiatric unit to which she had been transferred from a medical ward, where she had been admitted with severe chest pain. Initially she seemed quite intact psychologically, but on closer questioning she claimed that her heart was "split in two" and ready to fall out. Her Hamilton score was 59. There was no previous personal or family history of severe depression. Mood-elevating drugs were prescribed, without any success. When ECT was suggested to the patient, she replied that her brain was "rotten" and that it would be a waste of time to treat her. After 6 unilateral ECTs she had a surprising metamorphosis into a very pleasant and capable, although somewhat lonely, woman who was subsequently able to cope quite effectively with an impending change in her living situation. At 1-year follow-up she was symptom free and had a Hamilton score of 5.

Case 4. A 52-year-old mother of five had been well for most of her life with the exception of a hysterectomy at age 42. About 6 months prior to seeing her physician, she experienced the onset of pain in her upper right cheek with occasional "shooting pain over the top of my head and down my spine." During the ensuing several months her appetite diminished, she lost approximately 15 pounds, and her interest in her everyday household chores diminished to the point where she was spending her days in bed. She complained to her physician of poor appetite and loss of interest in food, occasional palpitations, shortness of breath, and a "full, uncomfortable feeling" in the upper left side of her chest. Her physician noted that she appeared sad, and when he asked her specifically if she was depressed, she admitted that she was but added emphatically that it was due to her severe pain and that her problems were certainly physical. After an extensive work-up her physician prescribed a regimen of

imipramine, but it was discontinued after she complained bitterly of dizziness and dry mouth.

After the patient had undergone many complete examinations by various specialists and continued to complain of severe pain, her physician arranged for an interview with her and her husband. Her husband reported many bizarre symptoms and increased suspiciousness. He also said that the patient had talked about being punished, about having a brain tumor, and had spoken of death on several occasions. It became somewhat more clear at this point that her pain might be a screen for a severe and even delusional affective illness, and a psychiatric consultation was arranged. The patient's Hamilton score was 53.

The patient received a total of 10 unilateral ECTs, with initial brightening of mood and disappearance of vegetative signs and symptoms. Her pain persisted until the seventh ECT and then disappeared. At 6-month follow-up the patient was essentially back to her former normal self and was asymptomatic. Her husband reported that she occasionally complained of mild numbness in the areas previously described as painful, but these complaints were transient. Her Hamilton score at 6-month follow-up was 11.

Nonresponders

Case 5. The 73-year-old wife of a dentist developed maxillary facial pain 20 years prior to psychiatric consultation, after her discovery of her husband's brief affair some years earlier. After consulting various physicians at that time, she was able to "tolerate" the pain, which was relieved by intermittent use of carbamazepine (Tegretol). Shortly after her husband's semiretirement 2 years prior to psychiatric consultation, her pain worsened and she withdrew to her bed, with his almost constant ministering to her. One year prior to her admission, she was admitted to a psychiatric hospital under somewhat vague circumstances and received 12 ECTs with quite striking improvement. Over the 12 months prior to her referral to another hospital for a neurosurgical evaluation, her pain slowly returned. Tricyclic medication was administered, but multiple side effects developed, prohibiting its further use.

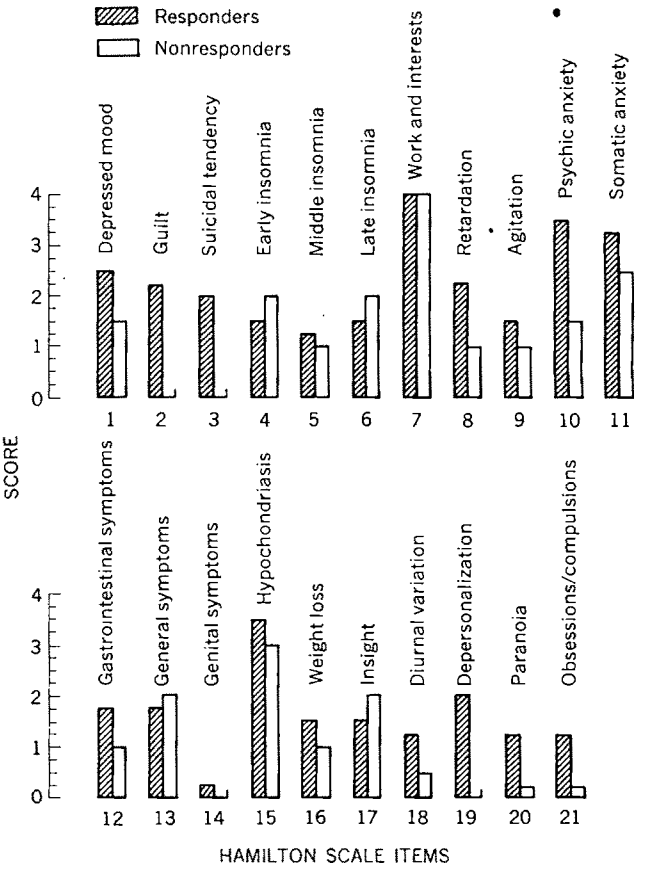
On examination, her behavior was coquettish and mildly inappropriate, with intermittent sadness, but there was no evidence of dementia. She repeatedly referred to her pain as burning—"like a slap." She suffered from marked constipation and loss of weight and appetite. Her Hamilton score was 32. After 7 unilateral ECTs her Hamilton score fell to 15, and her pain decreased somewhat but did not disappear. Shortly after her arrival home she began to complain of pain once again. At 6-month follow-up her condition was essentially unchanged from what it had been originally; her Hamilton score was 19.

Case 6. A 68-year-old bank teller with a 30-year history of headaches and pain in the right side of her face was referred for neurosurgical consultation by her local physician after unsuccessful treatment with many therapies, including acupuncture and tricyclic antidepressants. Her pain had intensified over the past 2 years since the retirement of her husband and their close involvement in an antique business. Her medical history revealed that she had cared for her ailing mother until the latter's death and that at age 35 she had married the vice-president of the bank in which she worked. Since her husband's retirement she had spent much of her time in bed, with him caring for her, and much of their life together focused on searching for new relief for her pain. The patient's Hamilton score was 25.

She appeared depressed on mental status examination and was begun on a course of ECT after an unsuccessful trial on antidepressant therapy. After 9 unilateral ECTs the patient's condition had changed little; she returned home to essentially

FIGURE 1

*Pretreatment Mean Scores on Individual Hamilton Scale Items**



*Higher scores indicate increased pathology.

the same situation, refusing psychiatric or medical follow-up at the referring hospital. At 5-month follow-up she had not sought further consultation and had remained at home, spending most of her time in bed. Her Hamilton score at that time was 22.

DISCUSSION

Figure 1 presents the responders' and nonresponders' mean scores on individual Hamilton items. This is an uncontrolled study, and conclusions must be tentative. However, the Hamilton scores suggest that ECT may alleviate both the pain and depression of depressed, chronic-pain patients who present with guilt, psychomotor retardation, suicidal ideation, increased agitation, anxiety, depersonalization, and paranoia. It is also of interest that the two nonresponders were the oldest in the group and had suffered from pain for 20 years or more.

The cases presented highlight the problem of potentially undertreated depressions with somatic symptoms, in both medical and surgical settings. Our experience with these patients confirms Bradley's suggestion (12) that the onset of pain coincident with depression is related to relief of both with ECT and Ziegler and associates' impression (6) that conversion symptoms includ-

ing pain in patients over the age of 40 may be related to depression. These cases are also presented to demonstrate that the application of an easily administered depression rating scale may be useful in documenting depressive illness in this group. It should be stressed that these selected patients with high Hamilton depression scores were followed closely, with attention to psychosocial set, and provisions for adequate follow-up and family support were made in each case. Difficulties may loom ahead for an uncritical application of ECT without attention to these matters.

These patients represent one subgroup of a chronic-pain population presently under study, and this report is intended to alert physicians to the possible use of ECT in depressed patients presenting with pain syndromes. It appears from these cases that ECT may alleviate the symptoms of depression and pain in a significant number of patients who have been unsuccessfully treated with antidepressant medication.

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The Depressive Syndrome: A Follow-Up Study of 130 Professionals Working Overseas

BY LUCY JANE KING, M.D.

A four-year follow-up of professional personnel who had been working overseas indicates that the depressive syndrome was the most common diagnosable psychiatric illness in this population. The study also shows that in this context the syndrome had a good prognosis. It therefore seems reasonable not to exclude persons with diagnosable depression from assignment abroad but, rather, to identify the syndrome and recommend necessary treatment.

INTERVIEWS HAVE BEEN CONDUCTED with 130 professional personnel from the United States working in 12 countries in Asia, Africa, or Latin America before and after their terms of service overseas, which lasted from two to six years (mean, four years). This has made possible a follow-up study of psychiatric symptoms in persons who were chosen for work overseas because they were functioning well in professional roles and who were placed in an environment where they would face cultural shock (1). As stated previously in a report on the initial interviews of 104 candidates for service overseas (2), the most common psychiatric syndrome seen was depression. This brief report will focus on affective and other psychiatric syndromes, family history of psychiatric illness, and certain aspects of living and work situations abroad.

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METHOD

Interviews

Psychiatric examination. The structured interview used with the 130 professionals who were sent overseas required 45 minutes to an hour and a half. The interview covered family history, school history, job history, medical history, and a mental status examination. Symptoms of the following psychiatric syndromes were inquired about: depression, mania, schizophrenia, organic brain syndrome, antisocial personality disorder, alcoholism, drug dependence, hysteria, anxiety neurosis, obsessive-compulsive neurosis, and phobic neurosis (3).

Depressive syndrome. A subject must have reported at least one episode of five or more concurrent depressive symptoms of several weeks' duration or numerous episodes of at least a few days that were differentiated by the subject from his usual psychosocial adjustment in order to receive a diagnosis of depressive syndrome. The following symptoms were inquired about: 1) dysphoric mood (depressed, sad, low, blue, despondent, gloomy, disgusted, discouraged, worried, fearful), 2) appetite change, 3) weight change of several pounds, 4) change in sleeping habits (insomnia or hypersomnia), 5) hopelessness or despair about the future, 6) diminished ability to concentrate on usual tasks, loss of interest in usual activities, or decreased sexual drive, 7) feelings of self-reproach or guilt, 8) nervous, tense, irritable, or increased crying, and 9) recurrent thoughts of death or suicide or a wish to be dead.

Family history. Psychiatric syndromes in relatives of the subjects were inquired about. For the purposes of this paper we focused on family history of affective disorders and alcoholism, which are known to have an increased incidence in the families of patients with affective disorder (4).

Living and work situations abroad. Particular attention was paid to "primitive" living conditions, that is, a house very different from those in the United States (e.g., a "bush" house with a straw roof, electricity for only part of the day, if at all, no running hot water or no running water at all). In terms of jobs, those which required being on frequent call 24 hours a day were noted (e.g., a nurse in a small hospital with no physician available or teachers living on the premises of boarding schools and available 24 hours a day to deal with counseling as well as mechanical and all other problems). Finally, any single events that individual subjects interpreted as major stresses while they were overseas were noted.

Sample

The 130 subjects were usually followed up four years after the initial interview. Four of the subjects were of Oriental descent and the other 126 Caucasian, and 105 were married at the time of the initial interview and 25 single. Eleven of the single persons married during the follow-up interval. There were 72 women and 58 men in the total sample. At the time of the initial interview 41 subjects were candidates who had not yet gone overseas, and 89 were on furlough after at least one term of service overseas.

The locales to which the subjects were assigned ranged from isolated stations in the bush where there were no other foreigners nearby to cities like Hong Kong or Tokyo. The jobs involved a wide variety of activities, including the following: teaching at all levels from kindergarten through graduate school in English or in various other languages; medical work, in first-aid stations in isolated areas, in preventive health programs in developing countries, and in modern hospital facilities; administration of groups of national churches and mission projects; accounting and business management; counseling nationals and/or foreigners; translation and literacy programs; "circuit riding" regularly to a number of congregations; radio or television programming; construction of buildings; and agricultural projects.

RESULTS

Seventeen of the 130 subjects met the criteria for having a depressive syndrome (see table 1). Age, sex, marital status, whether a candidate or on furlough when first seen, family history of depression or alcoholism, and obviously severely stressful events or situations were not statistically significantly different by chi square analysis in those with a depressive syndrome compared with those with few or no depressive symptoms (see table 2).

Fourteen of the subjects had a history of five or more concurrent depressive symptoms at the time of the initial interview (subjects 1 through 13 and subject 15 in table 1). Only three of these continued to have five or more symptoms or to require psychiatric treatment during the follow-up interval (subjects 12, 13, and 15). Subjects 12 and 13 responded to treatment, and subject 15 was not severely disabled. Subjects 14 and 16 had five or more concurrent depressive symptoms during the follow-up interval for which they received treatment. Subject 14 had no history of depressive symptoms at the initial interview, and subject 16 had a few mild symptoms. Subject 17 was flown to the United States during the follow-up interval for emergency psychiatric hospitalization when his first and only manic attack reached psychotic severity.

Forty-two subjects reported no depressive symptoms either at the initial interview or at the follow-up interview (see table 2). Forty-seven reported from one to four depressive symptoms at the initial interview and the same or (usually) fewer symptoms at follow-up. Only 1 of these had sought professional help for depression. At the initial interview this subject had described depressive episodes lasting a couple of weeks a few times a year that included depression, anorexia, and difficulty concentrating. At follow-up he described a six-month episode of depression, loss of energy, guilt, and occasional hopeless feelings. He had consulted a psychiatrist a few times during this episode.

Eight people (not shown in the tables) reported from one to three depressive symptoms specifically related to a single event (e.g., death of a child or a spouse). For 5 of

TABLE 1
*Reported History of Depression of 17 Subjects with Five or More Concurrent Depressive Symptoms**

Subject	Age**	Sex	History of Depression Reported		Follow-Up Period
			At Time of Initial Interview	At Time of Follow-Up Interview	
1	27	M	A couple of depressive episodes lasting a few days each yearly	Occasional insomnia	3 years
2	22	F	A couple of depressed days monthly, including premenstrual depression	Depressed after death of infant son; recovered; no other depression	2 years
3	27	F	A few depressed days every few months	Rare depressed days; occasional insomnia	4 years
4	25	F	Occasional depressed days	Premenstrual crying	6 years
5	39	M	Occasional periods of "tensions"; family physician prescribed "tranquilizers"	None	3 years
6	33	F	Intermittently depressed for 2 years at ages 20 and 21; premenstrual depression; family physician prescribed chlordiazepoxide	Decrease in premenstrual depression while taking oral contraceptive	4 years
7	25	F	Depressed at beginning of first term overseas for 18 months	Occasional days with fleeting suicidal thoughts, usually when premenstrual	4 years
8	37	F	Occasional depressions lasting a few days; took diuretic when premenstrual	None	5 years
9	45	F	Had "nervous breakdown" during adolescence; depressed 2 years before interview	Occasional depressed "angry" days; relieved by diuretic if premenstrual	6 years
10	51	M	Brief mood swings; hospitalized for "rest" once; depressed 9 months before interview; received outpatient treatment and antidepressants	Mild depression lasting a few days less and less often	6 years
11	53	F	Depressed 4 years before interview; received inpatient ECT and outpatient psychiatric treatment and antidepressants	Brief intermittent depressions; depressed at brother's suicide but recovered	2 years
12	26	F	A couple of depressive episodes lasting a few weeks; a few days' postpartum depression	Intermittent depression; outpatient psychiatric treatment	5 years
13	29	F	Premenstrual depression while taking oral contraceptive and while pregnant; outpatient psychiatric treatment with antidepressants	Took tricyclic antidepressants while pregnant; no symptoms while taking drugs	2 years
14	27	M	None	Intermittent depressions; outpatient psychiatric treatment	5 years
15	28	F	Severe depression during first 6 weeks of first term overseas	Mild depressions a couple of times a year	5 years
16	36	F	Fatigue and crying premenstrually and when taking oral contraceptive	Gradually worsening depression; outpatient psychiatric treatment and antidepressants	4 years
17	37	M	Fluctuating moods: depression, trouble concentrating, irritability, self-depreciation, or euphoria	Gradually worsening mania for several months; inpatient and outpatient psychiatric treatment and lithium	5 years

*The symptoms included the following: 1) dysphoric or depressed mood, 2) appetite change, 3) weight change, 4) change in sleeping habits, 5) hopelessness or despair, 6) loss of ability to concentrate, general interest, or sexual drive, 7) feelings of self-reproach or guilt, 8) feeling nervous, tense, irritable, or tearful, and 9) recurrent thoughts of death or suicide. Dysphoric or depressed mood was always one of the symptoms.
**At the time of the initial interview.

these people the event had occurred before the first interview. None of these 5 subjects had experienced depression during the three- to five-year follow-up period. Three subjects who had reported no history of depressive symptoms at the first interview had from one to three symptoms related to a specific event at follow-up.

Nine persons (not shown in the tables) who were first seen while they were on furlough each reported one episode of one to four depressive symptoms associated with severe medical illness (e.g., hepatitis or malaria). These symptoms remitted when the medical illness remitted. None of these subjects had had depressive symptoms during the three- to five-year follow-up interval. Another person had no symptoms when first seen but had had depressive symptoms associated with an episode of severe eczema treated with cortisone during the follow-up interval.

No subjects met the criteria for a diagnosis of schizophrenia, organic brain syndrome, antisocial personality, alcoholism, drug dependence, hysteria, anxiety neurosis, obsessive-compulsive neurosis, or phobic neurosis. Six subjects (not shown in the tables) would have to be classified as undiagnosed by the criteria used (3). One woman reported a number of vague medical complaints, a few depressive symptoms, and anxiety attacks. She had been living in uncomfortable primitive conditions overseas. At a two-year follow-up, after living abroad in much more pleasant circumstances, she still reported multiple symptoms not readily attributable to medical illness. Another woman reported fairly typical anxiety attacks lasting

TABLE 2
*Comparison of Subjects with Varying Amounts of Depressive Symptoms**

Item	Subjects with No Depressive Symptoms (N=42)	Subjects with One to Four Concurrent Depressive Symptoms (N=47)	Subjects with Five or More Concurrent Depressive Symptoms (N=17)**
Men	23	23	5
Women	19	24	12
At time of initial interview			
Mean age (in years)	34	35	33
Candidates	21	10	7
On furlough	21	37	10
Married	29	39	16
Single	13	8	1
Family history of depression	18	14	6
Family history of alcoholism	4	8	2
Family history of both depression and alcoholism	0	1	0
At time of follow-up interview			
Living conditions overseas were "primitive"	9	5	1
Subject was on 24-hour call	10	6	1
Specific stress reported***	6	9	2

*Numbers in all categories except age indicate the number of subjects in that category. Excluded from this table are 6 subjects who were classified as undiagnosed, 8 subjects who were depressed only at the time of a single stressful event, and 10 subjects who were depressed only during a serious medical illness.
**These are the same subjects whose histories are shown in table 1.
***Specific stress refers to an event or situation that the subject noted was especially upsetting while overseas, e.g., the death of an infant overseas or the death of a close relative in the United States.

only two months when she was 28 years old. By age 39, however, she had had no other psychiatric symptoms. One man reported three episodes during his lifetime of suddenly awaking at night, shaking all over, and having heart palpitation. He had had no such symptoms during the follow-up interval of three years and no medical or psychiatric illness to explain the symptoms.

Three other persons had each had one unusual and apparently medically inexplicable episode of symptoms occurring during a period of busy work schedules and, in one instance, at the time of a parent's death. One woman had been bedfast and almost unable to move, but she gradually became asymptomatic within three weeks and had no further symptoms. One clergyman had suddenly stopped in the middle of a sermon because his notes seemed to make no sense. He slept for two days and had no further symptoms. A third subject reported an episode in college when he stopped studying for one week before examinations. During this week he had nausea and hypersomnia. None of these 3 subjects showed psychiatric symptoms during the follow-up interval.

DISCUSSION

Many studies of prediction of psychiatric illness in special circumstances have been conducted in the military (5–8). In general, the circumstances seem to fall into two categories: highly unusual environments (e.g., Antarctica or submarine duty) in which strict criteria were used for selection with good results, and routine, uncomplicated duties in which many psychiatric predictions turned out to be too severe and many subjects who were judged unfit performed well. In reviewing the experience in the Navy, Christy and Rasmussen (5) noted that the problem is not that of discovering psychopathology but, rather, that of assessing its significance when detected. In other words, if all persons with even the mildest psychiatric problems are screened out, the remaining personnel seldom develop psychiatric problems, but many of those excluded would probably not have developed psychiatric problems either.

Reviews of the literature on prediction of performance (9, 10) have stressed the need for and the lack of structured interviews. In prospective studies of Peace Corps volunteers (9, 11), unstructured interviews conducted by psychiatrists have not been of value in predicting development of psychopathology during service overseas. Follow-up studies of psychiatric diagnoses (12–14) have indicated high reliability among raters using structured interviews and systematically designed criteria for diagnosis. Longitudinal studies of the chronology of psychiatric illnesses have demonstrated that carefully designed criteria for diagnosis are predictive of outcome (3). The present study certainly demonstrates that subjects who do not have sufficient symptoms to meet specific criteria for psychiatric syndromes do not develop psychiatric illness, at least during one term of service overseas.

The subjects who were interviewed had been selected for competent functioning. Thus persons with psychiatric syndromes that have an onset early in life and are severe and chronic (e.g., schizophrenia, antisocial personality) were screened out. It is not surprising that depressive syndromes, which usually remit, accounted for most of the psychiatric illness observed.

Smith (11), in assessing Peace Corps volunteers, noted among personality characteristics negatively correlating with general competence such items as "feels a lack of worth, has low self-esteem, high level of anxiety, pessimistic, lacks energy, irritable, and preoccupied with matters of physical health." It is possible that some persons in his study who functioned poorly were depressed as defined in the present paper.

Paluszny and Zrull (15) examined 50 missionary candidates and recommended that 5 of them not be sent overseas. Two of those 5 had had depressive symptoms. It is not clear how chronic the depressive symptoms were in these investigations. Continuing follow-up of a total sample of over 500 subjects from whom the present cohort of 130 was drawn will provide additional information about prognosis in depressive syndromes in persons who have been working in foreign cultures.

There is a great deal of evidence that depressive syndromes in psychiatric inpatients (16) and outpatients (17) have a generally good prognosis, even though there might be exacerbations. Subjects in the present study who met criteria for depressive symptoms (see table 1) appeared

similar to patients seen in psychiatric practice. Indeed, several had sought treatment.

Eleven people who had depressive syndromes or a history of them when first interviewed did not meet the criteria for such syndromes during the follow-up interval. The 3 who continued to have a depressive syndrome during the follow-up interval were less severely ill than they had been before, although 2 of them required continued treatment. Three subjects who had not had depressive syndromes at the initial interview developed affective syndromes during the follow-up interval. One of them developed the most striking psychiatric illness seen in the group—mania that reached psychotic severity. It would not have been possible to predict this on the basis of history of psychiatric symptoms at the initial interview.

Thus, on the basis of follow-up after one term overseas, it seems reasonable on the one hand not to exclude persons with diagnosable depressions from overseas assignment but, on the other hand, to identify them and to recommend treatment when necessary.

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Treatment of Depression in Alcoholics

BY JON A. SHAW, M.D., PATRICK DONLEY, M.D., DONALD W. MORGAN, M.D., D.M.S., AND JAMES A. ROBINSON, M.S.

The authors compared two groups of depressed alcoholics given either placebo or chlordiazepoxide-imipramine in a double-blind study. Although depression decreased in both groups, there were no significant differences between them on any of three pre- and posttreatment measures. The Zung scale showed that medication decreased depression significantly; however, this finding was not supported by the Beck Depression Inventory or the Minnesota Multiphasic Personality Inventory, indicating the necessity for use of multiple assessment instruments.

ALTHOUGH THE HISTORY of alcoholism is replete with the failure to define and identify an "alcoholic personality" profile, there is evidence that alcoholics exhibit some common characteristics. Therapists engaged in treating patients with alcohol problems frequently report that their patients are clinically depressed. A number of studies indicate the high frequency with which depression is present in alcoholics when measured by different psychodiagnostic methods (1–6). The understanding of this clinical phenomenon has been hindered by marked individual differences in the alcoholic patients and by failure to use operational definitions of alcoholism and depression.

Because of the clinically observed relationship between alcoholism and depression, there have been a number of studies exploring the use of antidepressants in the treatment of alcoholism (7–9). In a double-blind study comparing imipramine to placebo, with dropout rates as the outcome measure, Ditman (10) found no significant effect of the antidepressant. Kissin and Charnoff (9) tested antidepressants such as amitriptyline and isocarboxazide in a double-blind design and were unable to demonstrate that any drug was superior to placebo in producing abstinence for a six-month interval. In more recent studies, Kissin and Gross (4) discovered that a combination of chlordiazepoxide and imipramine was more effective than either drug alone or placebo.

The present study further explores the relationship between alcoholism and depression, examining the effectiveness of the chlordiazepoxide-imipramine combination with depression and with dropout rates in a treatment program.

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The authors gratefully acknowledge the assistance of Ms. Patricia Figaro at the field site.

METHOD

The population for this study was 58 male patients seeking treatment in a multifaceted halfway house that included inpatient care for a period of no longer than two weeks and an outpatient program providing individual counseling, group counseling, chemotherapy, and strongly emphasizing Alcoholics Anonymous. It was the policy of the halfway house to administer disulfiram to every patient unless there were medical contraindications. Informed consent for the use of disulfiram was a condition for acceptance into this facility.

The mean age of the population studied was 31.6 years, with a range from 18 to 50 years. Forty-seven percent were married, 16 percent divorced, 36 percent single, and 3 percent separated. Fifty-two were on active duty in the United States Army and 6 were employed civilians. For the total sample, 52 percent had graduated from high school and 41 percent had attended college.

The diagnosis of alcoholism was established in accordance with the recommendations of the National Council on Alcoholism (11). Only patients reporting at least one of the major obligatory criteria (physiological dependence, tolerance, or a major alcohol-associated illness) were included in the study. Depression was operationally defined by the depression scale of the Minnesota Multiphasic Personality Inventory (MMPI), Zung's Self-Rating Depression Scale (12), and the Beck Depression Inventory (13).

Upon admission to the treatment program, all patients were evaluated by one of the psychiatrists participating in the study. Psychological testing, including the three measures of depression, and a questionnaire designed to gather detailed data concerning drinking habits, demography, family relationships, and work adjustment were administered. All of the subjects had been detoxified before entering the study. Inclusion in the double-blind study required the patient's informed consent, no medical contraindications to disulfiram (Antabuse), chlordiazepoxide (Librium), or imipramine (Tofranil), and geographic proximity for follow-up evaluation (within 50 miles of the halfway house). Of the original 58 patients, 30 met the established criteria for inclusion in the double-blind study. Fifteen patients received 40 mg of chlordiazepoxide and 150 mg of imipramine daily for an average

of 31 days; the remaining 15 patients received identical placebos on the same schedule. The patients were randomly assigned to the groups and neither patients nor treating psychiatrists were aware of whether active medication or placebo was being administered. The 28 patients who were not included in the double-blind study comprised the baseline group. All 58 patients were offered individual and group counseling and 250 mg per day of disulfiram as part of the total halfway house program. A psychiatric nurse administered all psychopharmacologic agents.

After approximately 30 days of treatment, both the active medication and the placebo groups were reevaluated, and repeated administrations of the MMPI depression scale, Beck Depression Inventory, and Zung's Self-Rating Depression Scale were completed. Attendance records were maintained for all 58 patients in the study. Those individuals who did not maintain contact for five consecutive weeks following admission into the study were identified as dropouts.

RESULTS

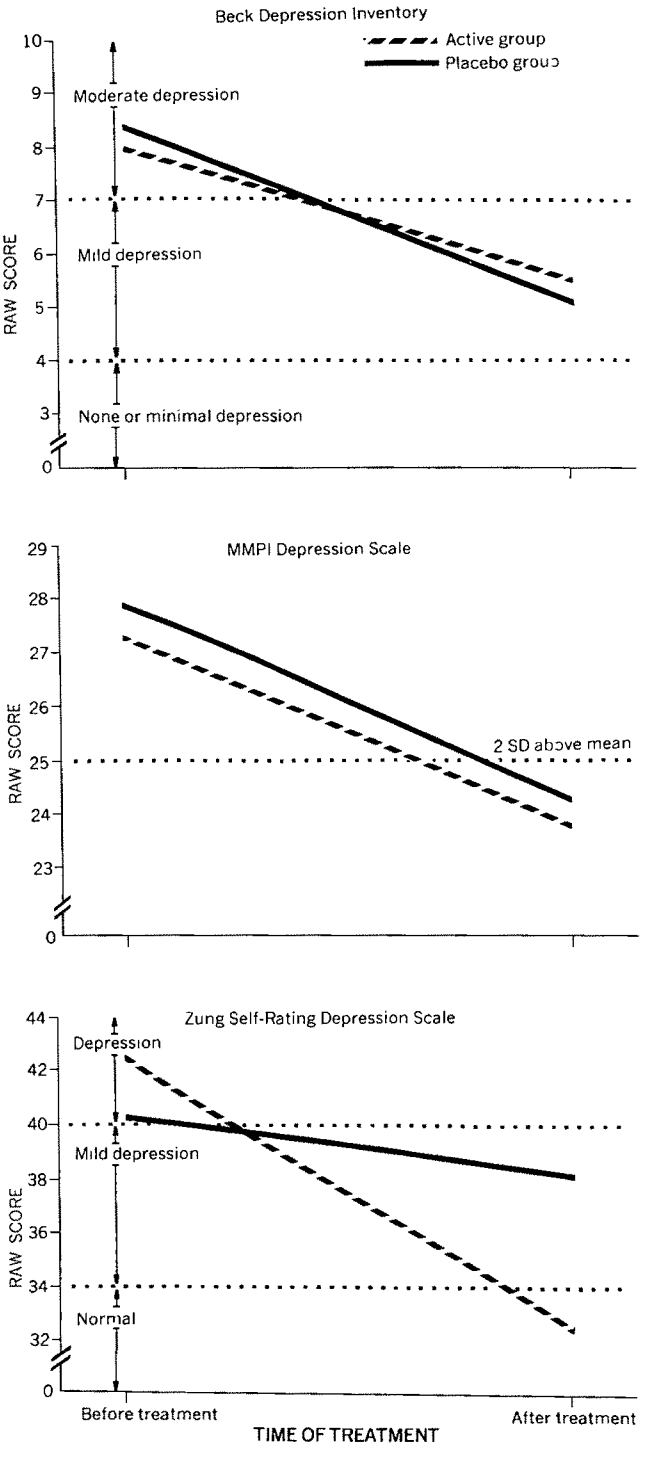
The seriousness of the drinking problems in this sample is illustrated in that 57 percent reported a drinking problem in excess of 2 years and 10 percent reported a drinking problem in excess of 10 years. Sixty-four percent indicated that their drinking had increased in the 6 months before treatment, and 66 percent were daily drinkers. In terms of their alcoholic preferences, no one preferred wine, 41 percent preferred beer, 31 percent preferred liquor, and 28 percent preferred liquor and beer in approximately equal amounts. The physiological effects of the chronic drinking behavior in this group of 58 patients are illustrated by the large number of physiological problems they reported. Blackouts were very frequent in this sample; only 16 of the 58 patients stated that they had never experienced blackouts and 22 percent reported having blackout episodes more than 10 times. Twenty-one percent of the group reported undergoing full-blown delirium tremens at least once and 2 patients had repeated episodes. Seventy-one percent described shakes following drinking; 50 percent noted gastrointestinal distress associated with drinking, and 9 percent admitted to either seizures or liver trouble.

Depression, as defined by the Zung, MMPI, and the Beck scales, was present in 98 percent of the patients on at least one of the depression scales. Eighty-eight percent of the total sample scored two and 40 percent scored three standard deviations above the mean on the MMPI depression scale, indicating a significant degree of depression. According to the Beck Depression Inventory, 76 percent were rated at least mildly depressed and 15 percent were severely depressed. Eighty-four percent of our sample was clinically depressed according to Zung's Self-Rating Depression Scale.

Figure 1 illustrates the effectiveness of the chlordiazepoxide-imipramine combination compared to placebo. On initial testing, no significant differences were found among the baseline group, the chlordiazepoxide-imipramine group, and the placebo group with any of the three measures of depression. As figure 1 shows, depression abated in both the active medication group and the placebo group over the treatment period. Retesting after ap-

FIGURE 1

Comparison of Pre- and Posttreatment Scores on the Beck Depression Inventory, MMPI Depression Scale, and Zung Self-Rating Depression Scale



proximately 30 days also revealed no significant differences among groups.

An analysis of the amount of change in depression from initial testing to 30 days into treatment indicated a decrease in depression on all three measures for the placebo group; however, this change was not significant. No significant differences in the amount of change in depression were noted in the active drug group for either the MMPI depression scale or the Beck Depression Inventory. A statistically significant decrease in depression, however, was noted for the active drug group on Zung's Self-Rating Depression Scale ($p<.05$). However, it is important to note that depression did decrease for all groups on all depression measures.

A significant difference in the dropout rate was found at five-week follow-up between those who entered the double-blind study and those who could not or chose not to do so ($\chi^2=9.07$, $p<.05$). Only 1 of the 30 patients who entered the study had left the treatment program. In contrast, 10 of the 28 patients who did not enter the study had dropped out of treatment. It is important to note that none of these 10 patients dropped out because of excessive distance from the treatment center. When dropouts were compared to those who remained in treatment, it was found that the dropouts scored significantly lower on the Beck Depression Inventory, but no differences were found on either the MMPI depression scale or Zung's Self-Rating Depression Scale.

DISCUSSION

Our findings confirm the numerous reports that note a high frequency of depression in an alcoholic population (1–6). This high frequency of depression was indicated with all three measures of depression. Any one of these measures identified at least 80 percent of the sample population as depressed. When each patient was rated on all three measures, 98 percent of the sample evidenced some degree of depression on at least one scale.

This study failed to find that the administration of 40 mg of chlordiazepoxide and 150 mg of imipramine daily for an average of 31 days significantly enhanced the decrease in depression for this patient population. The active drug and placebo groups exhibited a comparable decline of depression. The general abatement of depression in both groups appears to be determined by a number of variables: 1) the placebo effect alone in controlled studies of the depressed state is approximately 40 percent (14); 2) there is evidence that the discontinuation of drinking has a positive effect on alleviating the depressive condition (15); and 3) inclusion in this type of study has the effect of conferring on the patient an expectation that something positive may occur as a consequence (16).

When the amount of change in depression over treatment was analyzed for each depression scale, only Zung's Self-Rating Depression Scale in the active drug group indicated a significant decline. This finding may reflect the greater weight given by the Zung scale to physiological symptoms (weight loss, insomnia, decreased libido, loss of appetite, and generalized lethargy) as manifestations of depression. One may speculate that depression as measured by this scale responds to the active drug combination of chlordiazepoxide-imipramine and that this combination may exert its predominant effects by relieving the physiological symptoms so characteristic of depression. If we had used Zung's scale alone, we would be reporting positive results. However, the Beck Depression Inventory and the MMPI depression scale failed to indicate significant decreases in depression over treatment in either the active drug or placebo groups. The Beck Depression Inventory significantly differentiated dropouts from those who remained in treatment, while the MMPI depression scale and Zung's Self-Rating Depression Scale failed to do so. This may confirm the observation that the Beck Depression Inventory is a more sensitive indicator of the degree of cognitive awareness of subjective feelings of depression (17).

CONCLUSIONS

No differences were found between the active medication and placebo groups on any of the depression measures either before or after treatment. Depression abated in both active drug and placebo groups. It would appear that when compared to placebo the chlordiazepoxide-imipramine combination adds little to the treatment of chronic alcoholism in either retaining patients in treatment programs or reducing the degree of depression. Considering the relative danger of these medications, it appears that these drugs should be introduced to the total treatment program only when this is specifically warranted.

Our findings indicate the need to use multiple instruments in the measurement of depression. The lack of a consensually validated operational definition of depression and the apparent measurement of different dimensions of depression by different instruments caution against drawing conclusions with a single instrument.

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MMPI Delineation of a Subgroup of Depressed Patients Refractory to Lithium Carbonate Therapy

BY KENNETH M. HOUSE, M.D., AND RONALD L. MARTIN, M.D.

The authors found that in a sample of 26 severely depressed hospitalized patients, 5 patients with low depression and psychasthenia profiles on the Minnesota Multiphasic Personality Inventory did not show an antidepressant response to lithium carbonate. Seventeen of 21 depressed patients with high depression and psychasthenia profiles did respond to the antidepressant effects of the drug. They tentatively conclude that by using the MMPI it is possible to delineate a subgroup of depressed patients who are refractory to lithium carbonate therapy.

CONSIDERABLE INTEREST has been shown in correlating pretreatment variables with pharmacologic response (1, 2). However, the findings from these studies have not been conclusive, and diagnosis has remained the most reliable basis for the selection of a pharmacologic agent.

Schizophrenic patients usually respond to phenothiazines but not to tricyclic antidepressants or lithium carbonate. Depressive patients generally respond to the tricyclics or lithium carbonate but not to phenothiazines. Unfortunately, some patients in each of these diagnostic categories do not respond in the usual manner. Therefore, although diagnostic categories are useful as general guidelines, more sensitive pretreatment indicators are needed.

In the course of a research project studying the effectiveness of lithium carbonate as an antidepressant in severely depressed hospitalized patients, it was observed that response often varied according to differences in MMPI profiles. More specifically, it appeared that a low depression (clinical scale 2) and psychasthenia (clinical scale 7) profile was related to a lack of response to lithium carbonate and that a high depression and psychasthenia profile was related to responsiveness.

This led us to examine the patients more carefully to see how the group whose depression and psychasthenia profile was low (low 2–7 group) compared on other measurements with patients whose profile was high (high 2–7 group). We wanted to see if we had discovered a reliable way to predict pharmacologic refractoriness by means of a self-administered personality inventory.

At the time this work was done, Dr. House was Clinical Associate, Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health, Bethesda, Md., and Dr. Martin was a resident in the Department of Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif. Dr. House is now Assistant Clinical Professor, Department of Psychiatry, University of Southern California School of Medicine, and Dr. Martin is a resident in the Department of Psychiatry, Washington University School of Medicine, St. Louis, Mo. Address reprint requests to Dr. House at the Los Angeles County-University of Southern California Medical Center, Adult Psychiatric Outpatient Clinic, 1237 N. Mission Rd., Los Angeles, Calif. 90033.

METHOD

Twenty-six patients diagnosed as having primary affective disorder, depressed type, according to the criteria of Winokur and Clayton (3) were hospitalized on two 12-bed research wards at the National Institute of Mental Health. These wards were specifically designed for the longitudinal collection of behavioral and biochemical

data and for the treatment of patients with affective illness.

All of the patients were in good health as judged by medical history, physical examination, chest and skull X rays, EEG, and laboratory tests that included hematologic, renal, and hepatic function studies.

Both unipolar and bipolar depressive patients were included. The unipolar patients had depression characterized by psychomotor retardation or agitation, anorexia, weight loss, sleep disturbances, depressive thought content (often of psychotic proportions) dominated by feelings of hopelessness and worthlessness, preoccupation with guilt, and suicidal ideation. These patients had no history of mania or hypomania.

The bipolar patients had depression like that of the unipolar patients. All of them also had a history of at least one documented manic or hypomanic episode characterized by motor and verbal hyperactivity, pressure of speech, flight of ideas, provocative intrusiveness in interpersonal relations, and, often, euphoria or elation. All of the bipolar patients were depressed at the time of the study, and all showed no signs of mania or hypomania.

Diagnosis was established on the basis of interviews by two members of the research staff (a psychiatric social worker and a psychiatrist), supported by information from close relatives, previous physicians, and previous hospitals as well as by psychological testing. All patients were medication free during the diagnostic evaluations and baseline measurements.

All of the patients were given the Current Group Form of the MMPI within the first week of admission, before any pharmacotherapy was initiated. The tests were scored in the usual manner for nine clinical scales (hypochondriasis, depression, conversion hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, hypomania, and social intraversion). The masculinity-femininity scale was omitted. The three validity scales, lie, infrequency, and correction, were also scored. Scores were K-corrected to T scores (4, 5).

The sample was divided into two groups on the basis of MMPI profiles: those whose depression (clinical scale 2) and psychasthenia (clinical scale 7) profile was low (low 2–7 group) and those whose depression and psychasthenia profile was high (high 2–7 group). The T scores of the low 2–7 group were less than 70 on both the depression and psychasthenia scales, and neither of these scales was among the top four rank-order scales. The T scores of the high 2–7 group were more than 70 on both the depression and psychasthenia scales, and both scales were among the top four rank-order scales. (By rank order scales we mean the ordering of the eight clinical scales according to their T-score magnitude. The first rank-order scale would be the highest appearing scale on the profile graph, and the eighth rank-order scale would be the scale with the lowest appearance on the graph.)

The two groups were evaluated on the following measurements: age, sex, whether unipolar or bipolar, number of previous depressive or manic episodes, age at initial affective episode, family history of affective illness, length of current episode and length of current hospitalization, time between onset of current episode and institution of lithium carbonate therapy, clinical rating of depression, anxiety, and psychosis for the five days immediately preceding the use of lithium carbonate, and clinical rating for depression, anxiety, and psychosis on the day the MMPI was taken.

Lithium carbonate was administered in 300-mg capsules on a double-blind basis. Supplemental placebo capsules were added to keep the total number of capsules constant. Drug-related procedures such as blood sampling were also held constant for both groups. A placebo period of at least 6 days preceded the lithium carbonate period. Each lithium carbonate period lasted for at least 12 days.

An initial dose of lithium carbonate was set by estimation according to weight and age. The doses ranged from 900 to 1500 mg a day and were designed to reach therapeutic serum levels of 0.7 to 1.3 mEq/L. Serum lithium levels were reliably (SE=.02) determined using a modification of the method of Helm and Andriesse (6).

Using the 24-item, 15-point Bunney-Hamburg Scale (7), which is designed to systematically evaluate affective behavior on psychiatric wards, each patient's mean depression rating for the five days immediately preceding the administration of lithium carbonate was compared with his mean depression rating for the last five days of lithium carbonate administration.

Response was scored as complete if there was a decrease in the mean depression rating of at least 3 points, definite if there was a decrease of between 2.0 and 2.9 points, significant if there was a decrease of 1.4 to 1.9 points, or "no improvement" if there was a decrease of less than 0.6 points, no change, or an increase in the rating. Any improvement above 1.4 points was significant as measured by Student's t test.

RESULTS

In our sample of severely depressed hospitalized patients, 5 showed low 2–7 profiles and 21 showed high 2–7 profiles. None of the 5 patients in the low 2–7 group showed any improvement while on lithium carbonate therapy. In fact, all but 1, who showed no change, showed an actual increase in their clinical depression ratings.

Four of the 21 patients in the high 2–7 group (19 percent) did not show statistically significant improvement while receiving lithium carbonate therapy. Of the 4 who did not show a response, 1 never reached the commonly accepted therapeutic serum lithium level of 0.7 mEq/L (his highest level was 0.58 mEq/L). Of the 17 patients who did respond to lithium carbonate, 8 showed complete remission, 6 showed definite clinical improvement, and 3 showed significant improvement, as defined previously in this paper.

The finding that none of the 5 depressed patients in the low 2–7 group showed an antidepressant response to lithium carbonate although 17 of the 21 patients in the high 2–7 group did respond is significant by the Fisher exact probability test ($p<.002$).

All 5 patients in the low 2–7 group were diagnosed as bipolar. Twelve of the patients in the high 2–7 group were bipolar, and 9 were unipolar. This difference is not statistically significant ($p<.09$ by Fisher test). The two groups did not differ significantly on any of the measurements listed previously except for the following: the clinical rating of depression was lower in the low 2–7 group for the five days immediately preceding the use of lithium carbonate, and the low 2–7 group had high rank-order and T scores on psychopathic deviate and mania scales and lower T scores on the hysteria scale.

DISCUSSION

If replicated, the correlation of MMPI profiles with refractoriness to the antidepressant effects of lithium carbonate will have important implications. There is evidence (8) that lithium carbonate is an effective antidepressant for at least some depressed patients. The MMPI may prove to be a useful tool in delineating a nonresponsive subgroup of patients.

We have stressed the refractoriness of the low 2–7 group to lithium carbonate rather than the responsiveness of the high 2–7 group. In our experience, most depressed patients have high 2–7 profiles. A high 2–7 group may therefore be quite heterogeneous and may include subgroups refractory as well as responsive to lithium carbonate.

There are weaknesses in our study that must be examined and clarified in future studies. Our sample of 5 low 2–7 patients is small. Our study did not involve less severely depressed outpatients. There were some significant differences by Student's t test between the low 2–7 group and the high 2–7 group: the patients in the low 2–7 group were less depressed just before the initiation of lithium carbonate therapy, although they were not less depressed at the time the MMPI was administered.

The MMPI is available to any psychiatric facility. It is safe, inexpensive, and can be scored and evaluated promptly, in contrast to a medication trial, the most common method of determining responsiveness within a diagnostic category. Medication trials are costly, time-consuming, and have the potential for adverse effects.

We hope this study will stimulate further interest in the isolation of pretreatment variables helpful in predicting pharmacologic response.

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EDITORIALS

New Recognition for Women in APA

1975 HAS SPECIAL SIGNIFICANCE for the women of the American Psychiatric Association for at least two reasons. First, this is International Women's Year. It is also the year when a new member of the family of APA organizational components, the Committee on Women in Psychiatry, has become a part of the Association's structure.

A little background may serve to put this second event in perspective. Although women represent 11 percent of the membership of APA, the voices of these women have not always been attended to. In 1972 a Task Force on Women in Psychiatry was created. Under the leadership of Dr. Nancy Roeske the group identified two issues that warranted immediate attention: problems concerning women in general, as reflected in psychiatry, and the special concerns of women psychiatrists. The task force (which included men as well as women) initiated projects that had both immediate and long-range potential for addressing the two issues. Contributions to the work of the task force were made both by more experienced APA members and by women trainees.

Early in its life the task force recognized the need for consciousness (and conscience) raising among both men and women in psychiatry. In panels and "rap sessions" held during annual meetings, sexist attitudes of men and women were identified and discussed. As one member pointed out, "Most of us are unconsciously sexist. We become aware of this only when we are specifically challenged about the sexist assumptions we've been raised with."

Women psychiatrists were surveyed to examine the role of women in psychiatry and the role of psychiatry in the lives of women. Findings from this pilot project, which also studied the characteristics of all those entering psychiatry, disclosed few significant differences between the men and the women; one of these—which was not unanticipated—centered on the family-career conflict. Further exploration of this problem is warranted in view of the need to break down sexist attitudes that continue to exacerbate the family-career conflict among many women psychiatrists and also among other career women.

Besides this pilot project the task force initiated the development of a talent bank of women psychiatrists and the preparation of a monograph summarizing the literature on women in psychiatry and the psychology of women. It participated in the preparation and selection of papers for a special section on Women in Psychiatry and Medicine in this journal in October 1973; women trainees especially found the content useful, and some were stimulated to become involved in the work of the task force. The group also strongly encouraged training directors to offer courses on the psychology of women.

The task force recognized early in its life-span the need for continuing activity in several areas of its interest. This awareness led to a recommendation for the appointment of a permanent APA component to deal with issues related to women in psychiatry. The APA Board of Trustees approved the recommendation in December 1974, to be implemented following the annual meeting in 1975.

This editorial thus serves to announce formally the arrival of the Committee on Women in Psychiatry as part of the permanent APA structure. Women and men alike, we can hope that it will continue the promising work begun by the task force to free psychiatric education and practice of the biases that can adversely affect all of us.

JEANNE SPURLOCK, M.D.

Dr. Spurlock is a Deputy Director of the American Psychiatric Association.

SIDS: An Opportunity for Primary Prevention

BETWEEN SEVEN AND EIGHT thousand Americans die each year of a disease that until 1970 had no official name (1). The sudden infant death syndrome (SIDS), a definite disease entity, is the major cause of death in infants after the first month of life. In a typical case an apparently healthy infant (usually between three weeks and six months old) is put down to sleep by his parents without any symptoms of illness except perhaps those of a slight cold. Some time later the child is found dead in his crib; there is no apparent cause for the death. At autopsy, minor signs of inflammation in the respiratory tract and lungs may be present, but otherwise the findings are normal.

SIDS disregards social class, race, religion, and season. Death is swift and painless, and it cannot be predicted or prevented. Research to date indicates that the cause of SIDS is not suffocation, regurgitation, aspiration of milk or another substance, or pneumonia. Although many hypotheses as to the cause of SIDS have been put forward, the etiology is as yet unknown.

The loss of a child to SIDS usually presents the surviving family with an emotional crisis of enormous proportions. Because of the sudden and unexpected nature of SIDS and the mysterious circumstances surrounding the child's death, families almost universally experience a feeling of somehow being responsible. Guilt, shame, fear, and anxiety are usually experienced by the survivors.

Since Lindemann's classic description (2) of the survivors of victims of the Coconut Grove fire in Boston, psychiatrists have been aware of the impact of an unexpected death on family members. He documented the disability that can occur when the normal grieving process is retarded, prolonged, or otherwise not allowed to run its usual course.

The psychiatric disability occurring in families losing a child to SIDS is often considerable. The death is never expected and always occurs suddenly in a normal infant who appears healthy. Numerous cases have been described in which parents were submitted to exhaustive examinations by police, firemen, or neighbors concerning the death of their infant. Accusations of child battering, abuse, or neglect are not uncommon; in some instances parents have been placed in jail or even indicted for murder. Even under the best of circumstances parents may be told erroneously that their child died of pneumonia, implying that the parents were negligent in not having the child examined and treated by a physician.

Unresolved guilt reactions have been known to lead to family breakups, emotional wounds, and a refusal to have subsequent children.

Parents are not the only victims. Siblings are sometimes implicated because at the time of such a death the parents need someone to blame. Displacement of anger onto the dead child's siblings is not uncommon. Patients have been seen who recall as an extremely traumatic experience the death of a sibling many years earlier, probably from SIDS. The grief and guilt reactions that are experienced can be pervasive and long-lasting.

Caplan (3) has pointed out, "Primary prevention is a community concept. It involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have a chance to produce illness" (p. 26). This suggests that SIDS represents a classic example of how crisis intervention by mental health professionals can prevent emotional illness from occurring.

Early crisis intervention, including information about the nature of SIDS, and the performance of an autopsy (and notifying the parents of the results) can help to prevent subsequent emotional illness in parents and siblings.

The National Foundation for Sudden Infant Death[1] stands ready to provide information to physicians and to families who have lost children to SIDS.

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BRIEF COMMUNICATIONS

The Iowa 500: Suicide in Mania, Depression, and Schizophrenia

BY GEORGE WINOKUR, M.D., AND MING TSUANG, M.D., PH.D.

Long-term (30- to 40-year) follow-up data for 76 manic patients, 182 depressives, 170 schizophrenics, and 109 controls showed that 10 percent of the schizophrenics, 8.5 percent of the manics, and 10.6 percent of the depressives who were deceased had died by suicide. None of the controls had committed suicide. The authors suggest that suicide is a significant outcome factor in all three of these illnesses and is likely to occur at an earlier age in schizophrenia than in the other illnesses.

IN A STUDY of 134 people who successfully committed suicide, Robins and associates (1) were able to make a diagnosis of manic-depressive illness in 55 percent, chronic alcoholism in 28 percent, and schizophrenia in 2 percent. Although it appears that schizophrenia accounted for few of the suicides, it remains possible that suicide as an outcome of schizophrenia could be a significant problem. Affective disorders are far more common in the population than schizophrenia, and it is quite possible that the rarity of suicide among schizophrenic patients is simply the result of the fact that there are fewer schizophrenics at risk in the community than there are patients with affective disorders (2).

In long-term follow-ups, the proportion of patients with affective disorders who committed suicide was 13 to 16 percent of the total deaths (3). In shorter term follow-ups (i.e., a few years), the proportion of suicides was closer to 35 to 60 percent of the total deaths (3).

Lindelius and Kay (4) reported data on mortality among schizophrenic persons in Sweden and found that the significantly increased mortality in recent years was due mainly to an excess of suicides.

This paper presents preliminary material from a large follow-up study concerned with suicides among manic, depressive, schizophrenic, and control subjects. The data are presented to determine whether suicide is a significant outcome in these three illnesses.

Dr. Winokur is Professor and Head and Dr. Tsuang is Associate Professor and Chief Staff Psychiatrist, Department of Psychiatry, University of Iowa College of Medicine, Iowa City, Iowa 52242.

METHOD

Two hundred schizophrenic, 100 manic, and 225 depressive patients who had been hospitalized between 1934 and 1944 were identified and diagnosed according to strict criteria. A control group of 160 nonpsychiatric patients was added to these 525 patients. This control group represented a stratified random sample of appendectomy and herniorrhaphy patients hospitalized during the same time period and in the same medical setting (University of Iowa Hospitals). The criteria and methodology have been fully described in other publications (5–8). In addition to using the follow-up information in the hospital charts of patients, we conducted telephone and personal interviews.

RESULTS

Table 1 presents data on the patients for whom follow-up material was available. Of the 25 suicides, 17 had been noted in the follow-up portion of the chart and 8 were identified in the subsequent 30- to 40-year fieldwork follow-up. The results indicate that for the individuals followed up, those admitted for depression had a higher frequency of suicide (7.7 percent) than those admitted for schizophrenia (4.1 percent), with the manic patients falling in between (5.3 percent). However, the differences did not reach statistical significance. None of the control patients had committed suicide.

Although manic individuals do not often commit suicide, they usually become depressed at some time during their lives; when this happens, they are at risk for suicide. The percentage of suicides per total deceased persons for schizophrenics, manics, and depressives was similar.

Our current data for age at time of suicide by sex and diagnosis (with 40 years of age as the cutoff point between "younger" and "older") indicate that the schizophrenic patients were younger as a group than either the manics or the depressives (table 2). This trend becomes more pronounced if 45 years of age is used as the cutoff point; 6 of the 7 schizophrenics but only 2 of the 14 de-

pressives committed suicide before that age. The significance of this trend may well result in an overall reduction in the percentage of suicides among schizophrenic patients per total deceased by the time the entire sample is deceased. It may be that schizophrenics who are going to commit suicide will do so at a young age and that the 7 schizophrenic suicides shown in table 2 therefore represent the majority of those who will be observed. However, suicide appears to be significant in schizophrenia.

TABLE 1
Incidence of Suicide Among Proband and Control Groups in a 30- to 40-Year Follow-Up Study

Item	Schizophrenics	Manics	Depressives	Controls
Total number followed up	170	76	182	109
Number of suicides	7	4	14	0
Percent of suicides	4.1	5.3	7.7	0.0
Number deceased at follow-up	69	47	132	37
Percent of suicides among total deceased	10.1	8.5	10.6	0.0

TABLE 2
Number of Suicides by Age, Sex, and Diagnosis

Age and Sex	Schizophrenics (N=7)	Manics (N=4)	Depressives (N=14)
Younger than 40 years			
Male	3	0	2
Female	1	0	0
40 years and older			
Male	3	2	6
Female	0	2	6

DISCUSSION

The frequency of suicide per total deceased in mania and depression in this study is similar to the frequency reported in previous studies (1–4). We were surprised to find that a nearly equal percentage of schizophrenic patients committed suicide. Since these patients entered the study long before effective drug treatment existed, it would appear that the natural history of schizophrenia is characterized by a relatively high risk of suicide. The influence of keeping schizophrenic patients out of the hospital and treating them in the community (now commonly accomplished) may have other effects on the suicide rate among schizophrenics.

A special aspect of this study is that systematic diagnoses were made on the probands in the study according to rigorous criteria that were not based on outcome. The criteria for schizophrenia predicted chronicity of illness, whereas the criteria for mania and depression predicted a remitting illness. At follow-up the frequency of suicide is significant for all three diagnostic groups; however, suicide seems to occur more often in individuals with affective disorders.

It would be important to determine whether there are differences in familial suicide in our three groups. In fact, a follow-up study of first-degree relatives of our probands is in progress, but no data are available yet. Of relevance to this question is the work of Lindelius (9), who studied suicide in parents, children, siblings, nieces, and nephews of schizophrenics, making comparisons with general population rates. He reported an increase in the observed over the expected number of suicides in mothers, sisters, nieces, and nephews. In a blind family history study, Winokur and associates (8) presented data on suicide in first-degree relatives of patients with affective disorder versus schizophrenia. The data, derived from very complete family history records on patients who had been hospitalized between 1934 and 1944, indicated a higher proportion of suicides in the parents and siblings of the patients with affective disorder than those of schizophrenics (3 percent versus 1 percent, $p<.025$). Combining the findings of the proband follow-up with the family history material, we may conclude that although the degree to which suicide is an outcome of both affective disorder and schizophrenia is significant, it is a more important factor in the former illness.

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The Relationship Between Hiatus Hernia and Tricyclic Antidepressants: A Report of Five Cases

BY MURRAY A. TYBER, M.D.

Of five patients who were receiving tricyclic antidepressants, two experienced an aggravation of preexisting hiatus hernia, and three with previously normal gastrointestinal X rays developed hiatal herniation. The author suggests that this group of drugs may exert an anticholinergic effect on the esophageal sphincter and reduce the tone of the esophagogastric sphincter, thus aggravating existing hiatus hernia or causing its development.

ANTICHOLINERGIC SIDE EFFECTS such as xerostomia, hyperhidrosis, and constipation are frequently encountered in patients receiving iminodibenzyl antidepressant agents. Interference with the autonomic control of sphincter function and the peristaltic action of hollow viscera may also occur. Megacolon, adynamic ileus, urinary retention, and bladder distention have been reported with tricyclic antidepressants (1–4). The following report indicates that this group of drugs also aggravates the symptoms of hiatus hernia and may cause the de novo development of hiatal herniation.

This paper describes five patients who either noted an increased severity in symptoms from preexisting hiatus hernia or who developed symptoms of hiatus hernia for the first time while receiving tricyclic antidepressant medication. In two patients, findings from gastrointestinal X-ray examination were reported as normal just after the institution of antidepressant medication and subsequently showed hiatus hernia after the patients had continued therapy. One patient who had a demonstrable hernia after two months of medication had had a normal gastrointestinal X-ray series 10 years earlier.

CASE REPORTS

Case 1. A 64-year-old woman who was taking digoxin and hydrochlorothiazide experienced mild symptoms of heartburn and eructation from a hiatus hernia that was first discovered in 1964. She had no history of dysphagia. Following the death of her mother in 1968, she had developed neck and shoulder pains, insomnia, weepiness, and anergy. A regimen of 25 mg of amitriptyline twice daily was prescribed, and her heartburn increased soon afterward. X-ray examination in October 1968 showed the previously visualized hiatus hernia, with minimal change.

Withdrawal of amitriptyline resulted in the reappearance of the patient's symptoms of weepiness, marked anorexia, and insomnia. Her weight fell from her usual 103 lbs. to 89 lbs. in three months, and amitriptyline therapy was reinstituted. Her hiatus hernia was treated with a bland diet, antacids, and the elevation of the head of her bed. A regimen of 25 mg of amitriptyline twice daily was continued intermittently over the next 4 years, with repeated unsuccessful attempts at withdrawal.

In 1972 the patient developed dysphagia. She could eat only pureed foods and had several choking episodes associated with regurgitation of meals. X-ray examination at that time showed considerable esophageal cicatrization and stenosis. Repair of the hernia resulted in some improvement in symptoms, but bougienage was necessary in order to control dysphagia due to persistent stenosis. Amitriptyline was successfully withdrawn in 1973.

Case 2. A 51-year-old woman without previous epigastric symptoms was started on a regimen of 25 mg of amitriptyline three times a day and 10 mg of protriptyline every morning for treatment of painful shoulder syndrome. Six weeks after treatment was begun, she developed heartburn, eructation, and substernal oppression. Short gastric series X rays showed a small hiatus hernia with reflux. The patient was taking no other drugs at the time.

Case 3. This 37-year-old man, who 10 years earlier had had a series of gastrointestinal X rays that were reported as normal, was treated with 10 mg of protriptyline twice daily for stiffness and pain in the shoulders and neck. Two months later, while still on this regimen, he developed severe epigastric and substernal pain with marked dysphagia. X-ray examination showed an irreducible hiatus hernia without reflux but with a gastroesophageal ring. The patient was taking no other drugs at the time.

Case 4. A 47-year-old woman developed insomnia, tearfulness, and bilateral shoulder pain with nocturnal exacerbation shortly after the death of her husband. Examination revealed that both of her shoulders were virtually "frozen" (i.e., totally lacking in lateral abduction). She had been on a regimen of 5 mg of chlordiazepoxide three times a day, and it was stopped at that time.

Two weeks after she began taking 75 mg of imipramine daily, she complained of epigastric burning. Findings from radiological examination of the esophagus and stomach were reported as normal. A second X-ray examination by the same radiologist five months later showed a small hiatus hernia. The patient had been taking imipramine continuously in the interim, with increasing severity of heartburn.

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Case 5. This 67-year-old woman complained of diffuse pains in the hips, thighs, and shoulders, with irritability and insomnia. A regimen of 25 mg of amitriptyline three times a day was prescribed, and the patient's pain lessened and her affect improved. Two months later, while still on this regimen, she developed heartburn. Findings from a short series of gastrointestinal X rays were reported as normal. The patient's epigastric distress disappeared after subsequent withdrawal of medication.

Three years later amitriptyline was prescribed for the recurrence of myalgia, and the patient developed heartburn soon afterward. A short series of gastrointestinal X rays then showed a small hiatus hernia. Five mg of protriptyline every morning was substituted for the amitriptyline, but the medication had to be withdrawn because of continuing severe epigastric pain.

COMMENT

The aggravation of symptoms of hiatus hernia is understandable in light of recent discoveries concerning the physiology and pharmacodynamics of the esophagogastric junction. Constant infusion catheter studies of the esophageal vestibule show an intraluminal pressure of 15 or more mm Hgb in normal subjects. Patients with gastroesophageal reflux have a sphincter pressure of 10 or less mm Hgb (5). Sphincter pressure is decreased by atropine and increased by bethanechol, a cholinergic drug (6). The administration of bethanechol, both orally and parenterally, has been shown to prevent radiologically demonstrable reflux in known regurgitators (7, 8).

Tricyclic antidepressants probably exert an anticholinergic effect on the esophageal sphincter, thus lowering pressure and allowing increased influx to occur in patients with hiatus hernia. The de novo appearance of hiatus hernia in patients 3, 4, and 5 suggests that the reduced tone of the esophagogastric sphincter is etiologically significant in hiatal herniation and that tricyclic antidepressants may actually bring about herniation in susceptible individuals.

These findings suggest that tricyclic antidepressants should be withdrawn from patients who are developing symptoms of esophageal reflux. A cautious trial of bethanechol concurrently with the tricyclics may be warranted in those patients who have minor degrees of esophageal symptoms and an irrefutable need for iminodibenzyl drugs.

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Medical Practice Without Antianxiety Drugs

BY MARTIN H. KEELER, M.D., AND R. LAYTON MCCURDY, M.D.

The benzodiazepines and hydroxyzine were removed from a statewide Medicaid pharmacopeia. Barbiturate sedatives, hypnotic and antipsychotic medication, and tricyclic antidepressants remained available, but no substitution was made for about two-thirds of the deleted ataractic medications. The authors conclude that most physicians regard ataractics as unique and do not use them interchangeably with the other drugs.

ON JULY 1, 1970, hydroxyzine and the benzodiazepines were removed from the Medicaid pharmacopeia of an entire state. Other drugs promoted as having antianxiety effects remained available. The ensuing changes in the prescription of psychotropic medications are the results of a large-scale natural experiment and indicate for what purposes physicians use hydroxyzine and the benzodiazepines. (For the purposes of this paper these drugs will be referred to as "ataractics.") Other drugs were deleted from the Medicaid pharmacopeia at the same time, but the amounts involved were so small that the changes in the prescription of psychotropic medication under Medicaid primarily reflect the deletion of ataractics.

The state uses a closed Medicaid pharmacopeia in which only specific drugs are available without special permission. The changes were made to save money; there was no desire to regulate medical practice. An advisory board in which only physicians voted agreed to the changes. Central records for the six months before and after the change constitute the data for this study.

CHANGES IN PRESCRIPTION OF PSYCHOTROPIC MEDICATIONS

Table 1 summarizes pertinent changes in the prescription of psychotropic medications. There was a loss of 748,000 dosage units of ataractics. The deleted drugs were available if physicians made a special request to prescribe them under Medicaid, but no physicians attempted to obtain these drugs by means of this mechanism.

There are four obvious ways to substitute for the deleted drugs. The first would be to substitute sedative barbiturates, which are the closest pharmacological analogues available. Prescriptions of these drugs did increase by 68,000 dosage units, which would account for 9.1 percent of the deleted ataractics.

If any of the ataractics had been used as hypnotics, another hypnotic drug could be substituted. The prescription of hypnotics did increase by 48,000 dosage units, which would account for 6.4 percent of the deleted ataractics.

A third type of substitution would be to use phenothiazines or other drugs used to treat schizophrenia and agitation as well as anxiety. The prescription of such drugs did increase by 115,000 units, which could represent 15.4 percent of the deleted ataractics. Some of the increase in the prescription of antipsychotic medication might reflect a substitution for 36,000 units of combination drugs (phenothiazines and tricyclic drugs) that were removed from the pharmacopeia. If such an assumption is made, only 79,000 dosage units of phenothiazines were substituted for ataractics, representing 10.6 percent of the deleted ataractics.

A fourth method of substitution would be to use a tricyclic antidepressant with antianxiety effects. The prescription of amitriptyline did increase by 38,000 dosage units. This would account for 5.1 percent of the deleted ataractics. It is, however, highly unlikely that many such substitutions were made. Two tricyclic drugs, nortriptyline and desmethylimipramine, were also deleted. Before their deletion, 30,000 dosage units of these two drugs had been prescribed. Methylphenidate, of which 44,000 dosage units had been prescribed, was also deleted. Most of the 38,000 dosage-unit increase in the prescription of amitriptyline probably represented a substitution for the 74,000 dosage units of other deleted antidepressant medication.

If we assume that all of the increased use of other drugs reflects a substitution for the deleted ataractics, no substitution was made for 64 percent of this group. If some of these increases are interpreted as substitutions for the deleted antidepressant and combination medications, there was no substitution for 74 percent of the deleted ataractics.

DISCUSSION

There are drawbacks in natural experiments. The data presented could reflect economic, seasonal, and administrative factors as well as the effects of removing ataractics from the pharmacopeia. The simultaneous removal of other drugs could create some uncertainty as to what was substituted for what. This is not a major problem,

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however, because the results are about the same whether one assumes that any increase in the prescription of another drug represents a substitution for a deleted ataractic or whether other explanations are given for increases in the prescription of some other drugs. No such experiment is likely to be conducted under controlled conditions, so it is useful to examine the results.

The principal conclusion is that no substitution was made for about two-thirds of the deleted ataractics. The uncontrolled factors in the study are not likely to be responsible for this, since most ataractics are prescribed in situations in which no other drug is considered to be an adequate substitute.

The paucity of substitution with sedative barbiturates (9.1 percent) is difficult to explain. Before the removal of the ataractics, the prescription of sedative barbiturates equaled 59 percent that of hydroxyzine and the benzodiazepines. Each class of drugs has its prescribing adherents, but most who use ataractics will not substitute barbiturates. The sedative barbiturates are the closest substitutes in terms of pharmacological effect (1), but they do not promote relaxation of skeletal muscles as do the benzodiazepines. The ratio of both the lethal and the tolerance-inducing dose to the therapeutic dose is significantly higher for the ataractics than it is for sedative barbiturates (2). The data cannot explain the basis of choices and nonchoices, but they do indicate that most physicians do not prescribe the classes interchangeably.

We are encouraged by the small amount of substitution because it suggests that many physicians are quite cautious in their prescription of barbiturates, phenothiazines, and tricyclic drugs.

The question remains as to why so many ataractic drugs were prescribed at all if no substitution was considered necessary. We conclude that most physicians consider these drugs to be significantly more innocuous than other psychotropic drugs due to the almost total lack of lethal overdoses, the rarity of hematopoietic, hepatic, endocrine, and extrapyramidal complications, and the low incidence of physiological addiction.

Nothing can come without a price. If a large percent of the population receives ataractics, a number of patients will experience unwanted reactions even if the rate per thousand uses is small. The ataractics may also generate psychological dependence, somnolence, ataxia, and undesirable changes in behavior.

The state mental health department, the state medical society, and the district branch of the American Psychiatric Association protested the deletions from the Medicaid pharmacopeia. Motions to restore the deleted benzodiazepines were initiated and debated regularly at meetings of the advisory committee that had recommended the deletions. Eventually this advisory group reversed itself and advocated the restoration of the benzodiazepines to the Medicaid formulary. However, the Commissioner of Public Welfare declined to act on the recommendation. As of April 1975, benzodiazepines were not included in the Medicaid formulary of the state.

TABLE 1
Changes in the Prescription of Psychotropic Medications

Medication	Comparison of Dosage Units Prescribed	
	January–June	July–December
Ataractics*	748,000	-748,000
Diazepam	381,000	-381,000
Chlordiazepoxide	288,000	-288,000
Oxazepam	23,000	-23,000
Hydroxyzine	56,000	-56,000
Sedative barbiturates	442,000	+68,000
Phenobarbital	262,000	+37,000
Butabarbital	180,000	+31,000
Hypnotics	242,000	+48,000
Methaqualone*	32,000	-32,000
Barbiturates	160,000	+27,000
Chloral hydrate	50,000	+53,000
Antipsychotics	384,000	+115,000
Thioridazine	218,000	+95,000
Chlorpromazine	114,000	-6,000
Trifluoperazine	27,000	+27,000
Prochlorperazine	9,000	+15,000
All others**	16,000	-16,000
Methylphenidate*	44,000	-44,000
Tricyclic antidepressants	157,000	+5,000
Amitriptyline	98,000	+38,000
Imipramine	29,000	-3,000
All others***	30,000	-30,000
Combinations of perphenazine and amitriptyline*	36,000	-36,000

*Removed from the pharmacopeia.
**Perphenazine, haloperidol, and thiothixene were removed.
***Nortriptyline and desmethylimipramine were removed.

The only remaining recourse is to take the matter to the courts, but no one has done so. There is some justification for making benzodiazepines available to Medicaid patients. These drugs are considered the drugs of choice for anxiety; they are widely used by non-Medicaid patients; and the cost per patient is low. The only reason for their unavailability is that so many patients would receive such treatment. It can be argued whether economic considerations should influence treatment decisions regardless of cost. To let economics determine treatment when the cost per patient is low is difficult to justify.

Medical and welfare organizations would probably react more vigorously to the deletions if death or disability resulted from the unavailability of benzodiazepines. The prevention of unnecessary discomfort is as much a part of medical practice as is the prolongation of life, but it is not so dramatic.

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Evaluation of Therapist Candidates

BY EDWARD J. LYNN, M.D., AND JACQUELYN A. NORDHOFF, R.N.

The authors describe one phase of a four-step procedure designed to more fully evaluate candidates for psychotherapist positions. All applicants must conduct an interview with a patient, which is observed and evaluated by a team of staff members to assess diagnostic skills. This procedure has not only proved valuable in the program for which it was designed but has been extended to other programs and proposed for use in peer review.

PROCEDURES FOR HIRING psychotherapists for a community mental health center appear to be no different than those used in hiring other professionals or nonprofessionals. Letters or calls are exchanged, formal application is made, a resumé and references are submitted, interviews are arranged, and a decision is made. A review of the literature indicates that therapists are not usually asked to demonstrate their therapeutic abilities before they are hired.

In many agencies psychotherapy is essentially a behind-closed-doors operation that is seldom open to any form of peer review. Most agencies (perhaps ours even more than others) are somewhat resistant to change (1). One of us (E.J.L.) became the fifth director of the St. Lawrence Hospital Community Mental Health Center (CMHC) in three years. His three previous years had been spent as a medical educator and evaluator, and he brought with him the belief that peer review is crucial to developing and maintaining quality care. Eight months after his arrival at the CMHC a rare opportunity presented itself for the introduction of such review.

On March 15, 1973, the center increased its services to alcoholics by opening a 20-bed inpatient unit. (Previously individual counseling and group therapy had been offered to alcoholics and their families on an outpatient basis only.) The expansion of the program created several staff positions, including two for alcoholism therapists. One of us (J.A.N.), who has a strong background in nursing education and a positive disposition toward peer review, was hired as coordinator of the program.

Since the program was somewhat separate from the rest of the center and there were no formal policies and procedures for hiring therapists, the director and program coordinator hoped that an interview process could be designed and implemented without much resistance and without provoking anxiety and distrust in the rest of the staff.

A four-step interview procedure was developed in which the applicant is allowed to experience all four steps or to drop out of candidacy at any point. If the staff members feel at some point that the applicant does not meet the standards of the program, they might choose to discontinue the process. Applicants for therapist positions must complete all of the following steps prior to final evaluation for hiring: 1) an employment application and resumé, 2) a personal interview with the program coordinator, 3) an interview with the therapists presently in the program, and 4) a patient interview session. This paper is written about the fourth step.

DESCRIPTION OF THE PATIENT INTERVIEW

The purpose of the important fourth step in the hiring procedure is to provide a way to assess certain qualities that cannot be determined through the evaluation of an application and a resumé or through personal interviews. Resumés may seem very impressive, with their lists of educational background, job experiences, and membership in professional organizations. However, these facts do not give an employer a picture of how the potential employee functions, nor do they give a clear idea of his personality. The typical personal interview also fails to provide a clear indication of the applicant's personality traits because it is often colored by mutual biases, by anxiety, or by the interviewee's attempts to "snow" the interviewer. Again, the interviewer cannot always clearly determine in the therapeutic interview how the applicant would function on the job. We believed that we could predict success in the job with greater validity through observation of a patient interview session conducted by the job applicant than through traditional methods alone.

The therapeutic abilities that are evaluated in the patient interview session include the following:

1. The ability to display warmth, interest in the patient and the problems, acceptance of the patient but not necessarily of the behavior, empathy, a nonjudgmental attitude, and a nonthreatening approach.
2. The ability to be supportive of the patient without being manipulated into the position of rescuer.
3. Diagnostic skills—the ability to determine where the patient is regarding attitudes, honesty, and insight.
4. The ability to make interventions that enable the

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patient to gain more information about himself and to progress in understanding.

A carefully planned procedure is conducted to evaluate these abilities. The applicant is scheduled to meet at the center with the program coordinator, who explains the purpose, objectives, and mechanics of the interview session in detail. The applicant is given a one-page instruction sheet to review after the explanation and a copy of the Patient Interview Evaluation Form (2), which was initially developed to assess psychiatric residents and which we modified slightly to suit our needs. This meeting is brief in order not to increase the applicant's anxiety but is flexible enough to allow time for questions.

The applicant is then introduced to the staff members who are to observe and evaluate the session and to the patient who is to be interviewed. These introductions take place in an informal setting on the inpatient unit. The group then leaves the unit to go to the center's audiovisual studio. This period of time allows the applicant and patient a few minutes to deal with salutations and reduce anxiety.

The patient is usually selected from currently hospitalized individuals on the alcoholism unit by the staff therapist, with consideration of the patient's physical and emotional condition. The therapist explains the reason for the interview and the interview procedure to the patient. There is a strong emphasis on the voluntary nature of the patient's participation.

The interview session takes place in the audiovisual studio on the first floor of the center. The studio is composed of an interview room with facilities for observation. The interview room is light and colorful, with comfortable bright orange and yellow couches and chairs. There is a coffee table, and ashtrays are readily available.

The patient and applicant are brought into the room by the evaluating group and are given an orientation on the placement of the microphone, the one-way mirror, and (again) the time limit for the interview.

The evaluating group is composed of at least the program coordinator, the director, and the alcoholism therapist. This group's role is to observe the interview session, assess the interview difficulty, and rate the clinical skills of the applicant with the previously listed objectives in mind. The observers use the Patient Interview Evaluation Form (PIEF), which calls for ratings in the following major areas: 1) developing and maintaining a working relationship, 2) data elicitation, 3) data utilization during the interview, and 4) termination.

The interview session is about 30 minutes long. The evaluating group observes the session through the one-way mirror, and if it seems that the applicant is not moving toward termination of the session after approximately 25 minutes, the program coordinator reminds him/her of the time limitation.

Following the termination of the interview session, the evaluating group meets with the patient and applicant. The patient is given a copy of the PIEF and an explanation of its use and is asked to complete the form while the group is meeting with the applicant. The patient is asked to return the form to the therapist.

The applicant is also given the PIEF at this time and is asked to complete a self-assessment. An evaluation meeting with the group that observed the interview follows shortly after the session. This 30-minute meeting is informal, and a free give-and-take exchange occurs. Several important aspects of the interview session are evaluated, such as the applicant's feelings, the difficulty of the interview, the patient's condition, the stages of the interview, and plans the applicant would have for the patient if he/she were the patient's therapist. At the end of this meeting, the program coordinator discusses privately with the applicant any questions or concerns that may remain. Both the applicant and the patient are notified of the results of the entire interviewing process after the program coordinator and director have gathered all the data and made a decision whether or not to hire the applicant.

ASSESSMENT OF THE PROCEDURE TO DATE

Four applicants for the two alcoholism therapist positions have gone through the four-step interview process; three of them met the objectives and standards of the program. One applicant appeared qualified on the basis of his resumé, and he seemed poised and able to interact skillfully during his first interview with the coordinator. In the patient interview session, however, he appeared very inadequate and was rejected.

The opposite situation existed with another applicant, who was almost rejected because of his credentials. His patient interview, however, was outstanding. He was hired and has proven to be an excellent therapist.

Since the initial pilot project, 10 more applicants have been screened in this fashion with similar success. The first two people hired are still with the program over a year later and are doing an excellent job.

BENEFITS—PRESENT AND POTENTIAL

In the employment interview process the applicant usually experiences a certain amount of anxiety. The fourth step of our procedure, the patient interview session, is even more anxiety producing than the average employment interview. Evaluation of applicants at the center was done with this stress situation in mind. The program coordinator and the director provided immediate support to the applicant during the evaluation session following the patient interview session in a free, relaxed atmosphere. The coordinator also found that applicants wanted to continue the interview session following the group evaluation meeting and that they needed this additional support.

Our sample of four is certainly too small to permit any major conclusions. In half of these cases, however, the interview proved crucial in the decision-making process—it led us to hire an applicant we probably would have rejected otherwise and to reject one we might well have hired on the basis of other evaluation procedures.

This interviewing mechanism has been extended to several other areas at the St. Lawrence Hospital CMHC. The format is now being used for the selection of therapists in other programs, including the psychiatric inpatient unit and the outpatient program. The positive results have led to a proposal by the director that patient interview procedures be used for peer evaluation as well. The education coordinator has set up a series of seminars for the coming year which will orient the entire staff to the procedure.

This method of assessing candidates has value for the patients as well. It was noted that the patients who were interviewed in this fashion seemed to gain positive recognition of their participation from other patients on the unit. The patients who participated also seemed to leave the session feeling positive about the encounter and the applicant. Most importantly, they seemed to feel better about themselves.

We plan to study the procedure more formally in the near future: we recently hired a research and evaluation expert and plan to examine the efficacy and economics of such an obviously time-consuming effort in the area of employment procedures. We would also like to use this process to determine in-service training needs.

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Some Guidelines for the Training of Foreign Medical Graduates: Results of a Special Project

BY JOHN F. MCDERMOTT, JR., M.D., AND THOMAS W. MARETZKI, PH.D.

Since over one-third of the psychiatric residency positions in the United States are filled by foreign medical graduates, there is a need to identify and correct both the emotional and cognitive problems of these medical trainees. To meet this need the authors describe the findings and recommendations that resulted from a project involving two psychiatrists from a Southeast Asian country who were given a specially planned year of training in Hawaii.

THE LARGE NUMBER of foreign medical graduates who train for psychiatry in the United States requires refinement of the principles that guide the training of such physicians. Over one-third of American residency positions in psychiatry are filled by foreign medical graduates, mostly in nonteaching state hospitals where it is alleged that they receive substandard training (1). Approximately one-fifth of the physicians practicing in the United States are graduates of foreign medical schools, and the trend has been going upward (2). In 1972, the last year for which figures are available, 7,943 graduates of schools in the United States and 6,661 foreign medical graduates were licensed; these figures indicate that a 50–50 split is not far off. Many foreign medical graduates stay in the United States, some as poorly trained and maladjusted psychiatrists. Others return to their own country disillusioned.

Some attempts are being made to identify both the emotional and the cognitive problems of the foreign medical graduate in the American training process (2–8) and to correct them by special learning experiences. While there has been a good deal of discussion on the subject of identifying the elements crucial in this kind of transcultural learning, systematic efforts to find principles that have been applied with some success in actual training programs in the United States have not yet been described in any detail. In the absence of good models, the usual practice is to teach foreign physicians as if they had been reared and trained in the United States or to encourage them indirectly and even directly to "become American" as quickly as possible in their thinking, feeling, and behaving.

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PROJECT DESIGN

At the University of Hawaii a specially planned intensive year of training in child psychiatry was carried out for two women psychiatrists from a Southeast Asian country. The training was designed to enable us to study the experience of these students and develop guidelines that could be applied in a more general way to foreign medical graduate training in the United States. The limitations of this study, which is based on a sample of two fellows who were in special training for only one year, are well recognized. However, our emphasis on frequent reports by both faculty (who especially noted culture-related aspects of the learning process) and trainees (who filled out weekly critical incident reports of their most and least relevant experiences) would seem to give this study an in-depth if not a broad basis for the understanding of the process of training foreign medical graduates in the United States.

Behavioral and social scientists as well as clinicians have learned a great deal about the adaptation and changes in attitudes of persons who leave their own country. Some observations are based on the experiences of temporary residents (sojourners), and others refer to permanent immigrants. Foreign medical graduates can be found in both categories.

It is widely recognized that living and learning in a foreign country are closely related to the maintenance of self-identity in an unfamiliar environment. It has been suggested that the capacity of sojourners to function effectively abroad is related to maintaining a balance between involvement with the host country and detachment from it. Good coping mechanisms to overcome the widespread experience of culture shock and cultural fatigue among those who are immersed in an unfamiliar culture and unprotected by artificially created residential enclaves do not necessarily overlap with good intellectual and professional qualifications.

Foreign medical graduates have no special protection in psychological responses to an unfamiliar culture. Additional pressures may arise because of their uncertainty about developing an innovative role and about their home country's acceptance of new ideas and new techniques (9). Beyond the specific experiences of sojourners in learning situations are those of migrants who intend to remain indefinitely or permanently in a foreign country.

Brody and associates (5) raised some general questions about the complexity of individual intrapsychic and interpersonal elements in migrants. They approached migration from a systems point of view as a process rather than an act. This orientation reflects realistically the experiences that various observers have noted in foreign medical graduates. If these personal experiences are seen in light of the suggestion that native-born Americans training in psychiatry have analogous intercultural experiences as they learn to deal with mental patients (5), it becomes obvious that the foreign medical graduate, whether a sojourner who plans to return to his home country or an immigrant who plans to stay in the United States, is faced with learning and adjustment situations that require special understanding and responses.

Foreign medical graduates who have made the decision to migrate permanently encounter different problems than do those who plan to return to their own country, but many of the experiences coincide. It has long been recognized that during his time away from his home country the sojourner goes through phases of optimal adjustment and stress. The cyclical nature of adjustment and its impact on learning became evident in our close monitoring of the training of the two foreign medical graduates in psychiatry who spent one year in Hawaii.

In view of our experience with our trainees, it was not surprising that during their year in Hawaii they showed cyclical adjustment reactions similar to patterned changes and cycles reported in the literature. Becker (10) found a U-shaped cycle in which students from a foreign country initially assumed a hostile attitude toward the host country and its culture that gave way to detachment from their home country during the middle phase. A more negative orientation toward the host country appeared again just before they returned home. The cycle seemed characteristic of students from countries less developed than the United States.

THE TRAINING PERIOD

The two foreign medical graduates appeared to experience four distinct phases during the training period. Phase 1 can only be described as one of struggle and adjustment in which little was accomplished, partly because of the difficulties of adapting to Western culture. Phase 2 could be characterized as a receptive or collecting period, merging with phase 3, an integrative and selecting period in which new identities were built from material and experiences that had accumulated during phases 2 and 3 (which constituted the bulk of the year). Phase 4 was a closing-off period in which there was integration, but also depreciation and rejection of certain elements of the training experience.

The attitudes of our two foreign medical graduates were unquestionably the key variable upon which the outcome of the project depended. They determined the kind and degree of knowledge and skills that were absorbed, that is, overall achievement as well as the integration of the knowledge with developing skills.

The students' attitude at first was that American psychiatry was too expensive or fancy for them. They were reluctant to learn or employ techniques for fear that they could never use them at home. This initial period gave way to one in which the trainees displayed an attitude of new discovery of how to apply the things they were learning. Cultural attitudes toward patients, which seemed to interfere with the trainees' facility to regress emotionally and cognitively in order to reach their patients, were expressed in the demand that patients achieve more self-control. These attitudes appeared to interfere with learning new techniques except on those occasions when a positive experience with a patient influenced their attitudes

and broke through what appeared to be culture-bound constraints. An example of one of these constraints is seen in the statement, "Patients can't talk about their feelings at home; it isn't allowed in our country."

In the latter parts of phase 3 and during phase 4, questions as to whether new facilities and programs they had seen here could be introduced at home, e.g., whether a shelter for runaway teenagers would help runaways or increase the problem, demonstrated a further healthy development of the questioning of previously superficially admired U.S. methods and technology. This led to a final critical period in which there was considerable frank rejection of American methods and integration and synthesis of their own past with their new expertise.

ACQUISITION OF KNOWLEDGE AND SKILLS

Knowledge

As noted before, it appeared that little knowledge was accumulated during the first two months. The trainees stated that they read assignments over and over but remembered little. This occurred in spite of the faculty's attempt to very carefully integrate into the readings discussions of approaches that viewed American experiences in the light of applications in the students' home country.

After the first two months, an intensive learning phase began. The trainees began to discover and collect many theories in seminars. While they felt able to make use of this information "to see a case from different angles," their learning appeared to be more imitative than incorporative. Hypothetical cases were discussed from differing developmental points of view, but the faculty could not see that the trainees were integrating this information into their clinical practice. The trainees began to feel like experts in certain areas; they acquired circumscribed areas of knowledge about specialized disorders. They also experienced an emotional lift from the literature—from such discoveries, for example, as the fact that differentiation of autism from mental retardation is a key to understanding serious childhood disorders.

In general, an understanding of the theories they had learned during phase 2 began to appear in phase 3. The students began to think in terms of multiple causation and abandoned their style of automatic labeling. For example, mental retardation, which included many other disorders, had been their most frequent diagnostic response in the past, but now the trainees thought in terms of multiple causation. The ability to integrate and synthesize functional and organic factors was another major milestone that they experienced in the acquisition of knowledge.

Following this period, the trainees began to examine various syndromes and concepts transculturally. Complicated theoretical material such as communications theory was absorbed, retained, and at times even applied to solving clinical problems.

This peak of absorption and integration of new information, however, was short-lived. It gave way to a period of rejection of new knowledge, particularly during the last phase of training. However, the faculty felt that they could still see signs of the integrated effects (e.g., the ability to read critically) as proof that changes from the earlier imitative cognitive style had indeed occurred.

Clinical Skills

During the initial shock of the first two months, it appeared that the trainees were concerned that they were actually losing psychiatric skills they had learned in their own country and gaining none in return. While they gradually became more skilled in organizing case material into a systematic presentation, incorporating a variety of developmental and psychopathological points of view, there was no parallel increase in clinical abilities for actual data gathering with patients, formulation of a working diagnosis, treatment planning, or treatment skills. The students were easily discouraged by the difficult patients they encountered and concerned by the patients' lack of respect for a doctor and their lack of self-control. They had marked difficulty in establishing a therapeutic alliance, the vehicle through which they could do further work.

During phase 2 the students began to see staff and the nonforeign trainees as more skilled in working with patients than themselves. They then attempted to identify with the American student with whom they were paired. They saw the advantages of interdisciplinary team management of disturbed patients, using other staff members as therapeutic agents. They realistically abandoned the expectations they had of being able to do everything themselves (physicians had been overidealized in their home country).

During phase 2 the trainees rejected a variety of psychotherapeutic techniques. Psychoanalytic therapy was seen as too time-consuming for application in their home country, behavior therapy too impersonal and harsh, and family therapy impossible because in their home country family members could not express feelings toward each other. Concern over the independence and autonomy that psychodynamic individual and family therapies allege to promote was prominent. Interdependence and dependence are more accepted characteristics and a normal part of functioning in their culture, and striving for independence and autonomy was not considered to be a goal that should or could be transposed there.

The trainees wanted practical hints on how to influence their patients quickly. Occasionally they saw how they could influence a patient through the evolving relationship. However, the predominant negative attitudes of rejection of new skills with the rationale that patients at home would not be able to talk as freely about their feelings either in the home or in the office continued to prevail. At the same time they suggested that patients in their country would be more treatable by methods that rely heavily upon suggestion and advice.

Occasionally there were indirect evidences of the emergence of latent clinical identities that we could not directly observe. These were noted in the trainees' admiration for the way in which neurology and psychiatry worked together over cases, the integration of the func-

tional and organic components in assessment of cases and in approach to treatment, and the interdisciplinary approach to therapy.

CONCLUSIONS

In summary, if one were to graph the knowledge curve of these candidates over a one-year period it would show a steep increase in the third month, peaking in the eighth or ninth month and then dropping off somewhat until the end of the program. A skills curve, on the other hand, would begin at the same low level over the first two months and would show a much more gradual and slow incline. The pairs of curves would be somewhat different because of the two candidates involved, but a composite would show a great deal more development of knowledge than of skills, particularly clinical skills.

There are several implications from our study for the training of foreign medical graduates. Differences in attitudes and the many dimensions of doctor-patient relationships between the two cultures produce difficulties. Rejection of therapeutic modalities seemed related as much to the American faculty's inability to understand patients from the trainees' country as the trainees' inability to understand American patients. These mutual problems in attitude and conceptualization between faculty and trainee must be further studied because the acquisition of knowledge and skills is so dependent on them.

However, if one considers that foreign medical graduates go through phases in their training that are not related chronologically to our conceptualizations but to their emotional adjustment and adaptation to our culture and its training, then planning can be oriented toward these phases so that the cultural and conceptual gaps do not widen but, rather, close between trainer and trainees. The result will more likely show the trainees emerging as bicultural psychiatrists who have added and integrated a new form of experience into their own background, comparing and contrasting psychiatric problems and treatment in the United States with those at home.

Our findings were that trainer and trainee entered the program with somewhat divergent goals in spite of a considerable amount of preplanning. It is our impression that in most American training programs, in which this kind of planning and attempts to identify differences and commonalities in goals is not routine, the discrepancies and gaps become obstacles to learning and assimilation of knowledge and skills. However, if a period of time when personal and professional adjustment is difficult is identified at the beginning of training, this critical period can be softened by minimizing the trainee's sudden immersion with large numbers of patients or readings. Homesickness must be recognized, associations with colleagues from foreign cultures encouraged, and pressure reduced.

If this is done, the second phase of receptivity or collecting experiences and the third phase of integrating and selecting a new identity from material and experiences accumulated during phases 2 and 3 will be most productive and crucial in the formation of a psychiatric identity that is maximally effective in either culture.

Our phase 4, the closing-off period in which there is depreciation and rejection of certain elements of the training experience, is the transition between the end of training and the beginning of effective practice. Rejection of the training and practice of one's own culture may be a frequent counterpart to the rejection of American training and values. Sensitivity to and awareness of this as well as an attempt to open it up for discussion and "decompression" would seem useful. This technique could be added to the training experience of the foreign medical graduate in the United States. We hope that training programs throughout the United States will recognize and consider the phases experienced by our two foreign medical graduates instead of training phases that are largely chronological and culture bound and, perhaps, incongruent with the phases the foreign medical graduate experiences.

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Intentional Isoniazid Overdosage Among Southwestern American Indians

BY MAURICE L. SIEVERS, M.D., MICHAEL H. CYNAMON, M.D., AND THOMAS E. BITTKER, M.D.

A 30-month study explored the degree to which self-destructive behavior compromised tuberculosis therapy and prophylaxis among southwestern American Indians. The frequency of isoniazid (INH) overdosage paralleled the extent of INH usage in each tribe and the extent to which INH was prescribed for each tuberculosis category. The authors recommend the careful selection of patients for INH prophylaxis, the dispensing of small amounts at short intervals, the close monitoring of patient compliance with the prescribed drug regimen, and, possibly, the dispensing of individually wrapped tablets to inhibit the impulsive ingestion of massive amounts of the drug.

THE AMERICAN INDIAN is conspicuously vulnerable to self-destructive behavior and is also at considerable risk for the development of tuberculosis (1, 2). Previous studies have shown that suicide occurs twice as frequently among Arizona Indians as among their non-Indian counterparts (3). The new case rate for tuberculosis among Indians in the Phoenix area of the Indian Health Service (IHS) is 124 per 100,000 compared to a rate of 14 per 100,000 for the Arizona non-Indian population (4).

In order to control the Indians' high prevalence of tuberculosis and tuberculin reactors, the IHS has an extensive treatment and prophylaxis program involving isoniazid administration for a year or more. Isoniazid (INH) is used as the main therapy for active tuberculosis and as the only drug in the prevention of morbidity among subclinically infected people. Although INH is considered relatively safe when taken in a closely supervised treatment program, when ingested in excessive amounts it produces signs of acute intoxication, including tonic and clonic convulsions and metabolic acidosis (5–8). Overdosage can lead to death (8–9).

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No adequate data have been published regarding either the relative lethality of INH overdosage compared with other methods of attempted suicide or the categories of people and circumstances at the greatest risk for overdosage. Since INH administration may have potentially fatal consequences, we explored the degree to which self-destructive behavior among Indian people compromised tuberculosis therapy and prophylaxis. This report concerns the incidence, predisposing risk factors, and possible methods for reducing the frequency of intentional INH overdosage in American Indians.

METHOD

The investigation included all known suicide attempts, gestures, and completions occurring between January 1971 and June 1973 among Arizona Indians residing within the Phoenix IHS area (i.e., all those not on the Navajo and Papago reservations). This study population of 40,361 included the following tribes: Apache, Pima, Hopi, Maricopa, Yavapai, Hualapai, Havasupai, Chemehuevi, Cocopah, and Mohave, as well as off-reservation Papago and Navajo. Forty-nine percent of this population were men and 51 percent were women; 33 percent were 0 to 9 years old, 36 percent were 10 to 29 years old, 24 percent were 30 to 59 years old, and 7 percent were 60 years and older.

Suicide information was obtained from summary sheets completed by physicians for hospital admissions at the various Phoenix IHS area clinics and hospitals in Arizona. Correlative data were obtained from a suicide register maintained by the mental health section of the Phoenix IHS area and based on original reports from mental health professionals and paraprofessionals.

There were five previously described (10) categories of INH overdose patients: 1) cases of tuberculosis, 2) converters (persons whose tuberculin skin test increased at least 6 mm—from less than 10 mm induration to greater than 10 mm—within the preceding two years), 3) contacts (persons who had close contact with an active case of tuberculosis for a time period long enough to have become infected with *Mycobacterium tuberculosis*), 4) reactors (persons with 10 mm or greater induration on an intradermal skin test, using 5 tuberculin units of purified protein derivative), and 5) persons for whom INH was not prescribed, who usually obtained it from relatives. For this study, every Indian patient who ingested, with apparent suicidal intentions, at least 1.5 g of INH, either alone or along with other substances, was classified as an

INH overdose case. The amount of INH ingested was estimated from information supplied by observers and from clinical records of the quantity of medication dispensed: the number of INH tablets missing but unaccounted for by the quantity prescribed as medication during the elapsed interval was calculated.

In most cases, conclusive evidence was available to differentiate between a suicide attempt and an accident; for the few equivocal cases, the judgment of the local service unit physicians and mental health workers was accepted. Similarly, only one type of self-destruction—trauma or toxic ingestion—was usually employed, but when a combination of methods occurred, the patient was assigned to the category that, in the opinion of the investigators, had the greatest potential for lethality.

RESULTS

During the 30-month study period 450 Arizona Indians within the Phoenix area of the IHS were known to have attempted suicide, a mean annual rate of 447 per 100,000. There were 17 deaths, a completion rate of 3.8 percent, and a mean annual suicide rate of 16.8 per 100,000.

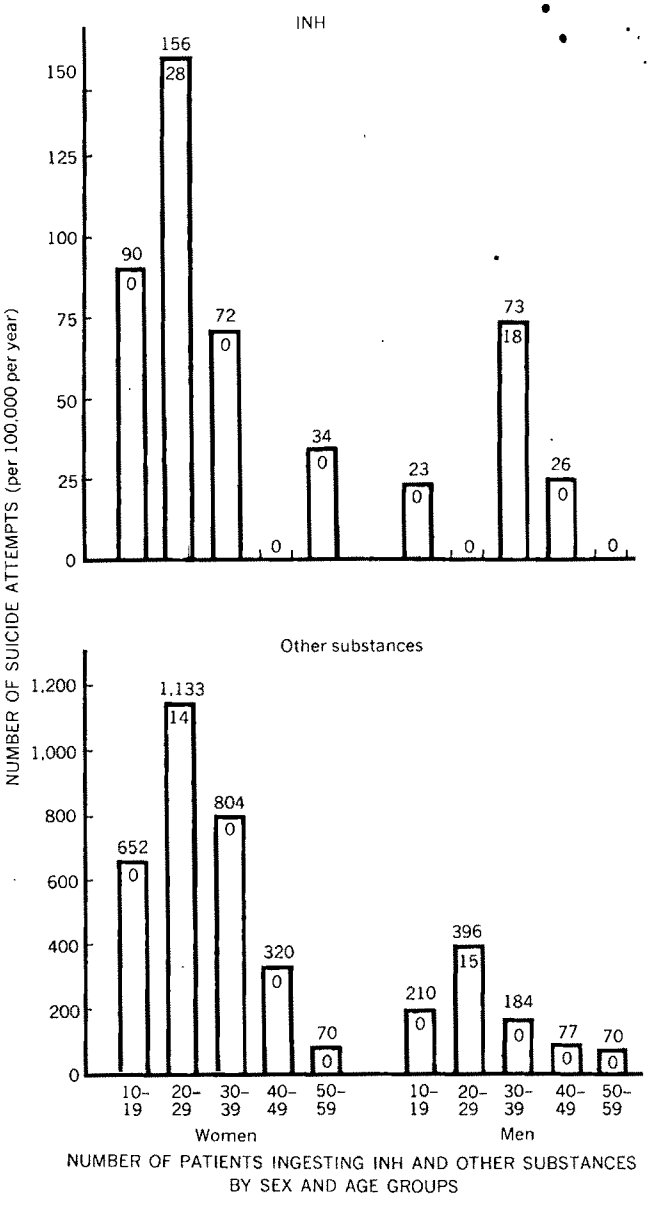
Many more Indians attempted suicide by ingestion (N=332) than by trauma (N=118), but the latter method more often (10.2 percent) resulted in death than the former (1.5 percent). Isoniazid was involved in 8 percent of the suicide attempts and in 17.6 percent of completed suicides. Whereas INH accounted for 10.8 percent of all ingestion attempts, 60 percent of the deaths from ingestion were due to INH. The rate of completion by ingestion of substances other than INH was 0.7 percent; the rate of death from INH overdosage was 8.3 percent ($p<.001$). Thus, the risk of dying from INH overdosage approached the lethality of trauma (10.2 percent). Among the 3 Indians dying from INH ingestion (all were dead on arrival at the service unit hospital), the estimated amount of INH ingested was large (more than 15 g) and the time interval between ingestion and presentation was prolonged (more than 4 hours).

Compared to men, women made many more suicide attempts (313 versus 137), used the method of ingestion more frequently (255 versus 77) and trauma as often (58 versus 60), but died from their self-destructive actions in smaller numbers (3 versus 14). The women had about the same predominance of INH overdoses (77.8 percent) as they had for all other ingestion overdoses (76.7 percent). Although men attempted suicide by ingestion much less frequently than women, INH accounted for a similar proportion (about 11 percent) of all of the substances ingested by both sexes. It is noteworthy that ingestion was responsible for all 3 female suicides but that 12 of the 14 male suicides resulted from trauma.

As shown in figure 1, the age distribution in suicide attempts was similar for INH and other ingested substances, and women had higher rates than men in each category. The highest attempt rate with INH, as well as with the other ingested substances, occurred among

FIGURE 1

*Suicide Attempts for Southwestern Indians by Method, Sex, and Age**



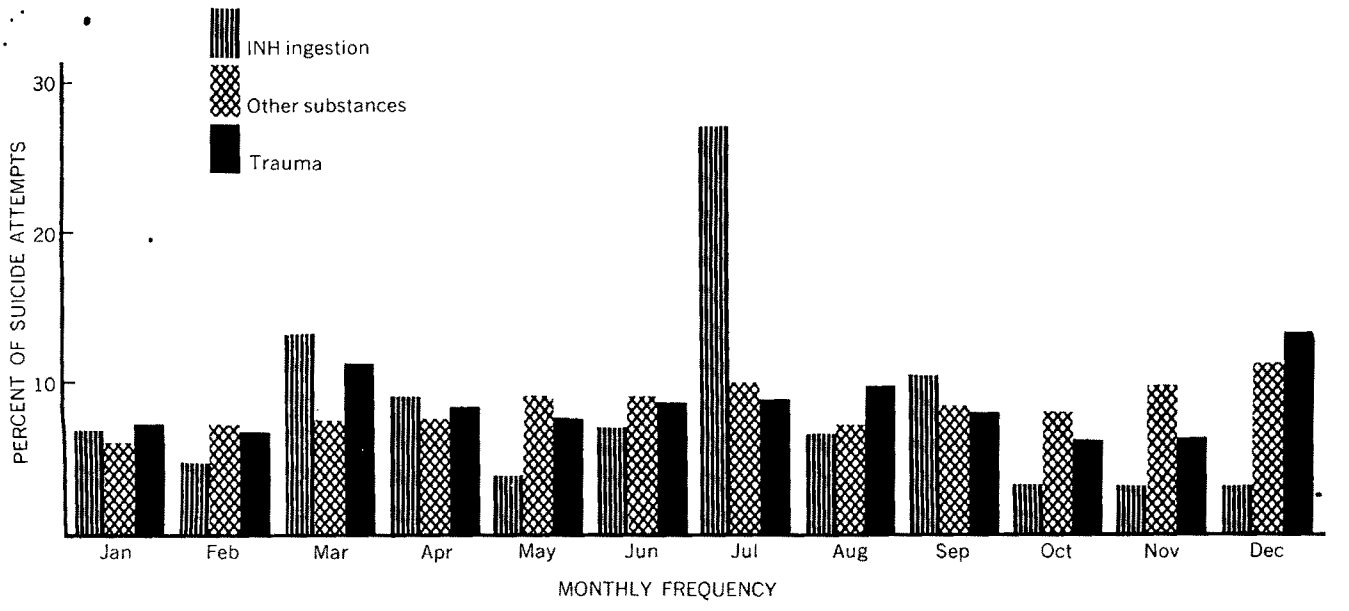
NUMBER OF PATIENTS INGESTING INH AND OTHER SUBSTANCES BY SEX AND AGE GROUPS

*Numbers within bars indicate completion rates.

women of the 20- to 29-year-old age group; 10 of the 17 (58.8 percent) suicide deaths and 4 of the 5 ingestion deaths occurred in the 20- to 29-year-old age group, a category representing only 21.1 percent of the study population at risk ($p<.01$).

The rates per 100,000 population for total suicide attempts versus completions were higher among the Apaches (932 versus 40) than the Pimas (764 versus 7) or the other Phoenix IHS area tribes combined (504 versus 26) ($p<.01$). This tribal pattern also occurred for INH overdoses, i.e., the Apache rates (per 100,000) were significantly higher (101 versus 10) than for the Pimas (14 versus 0) or for the other tribes (46 versus 3) ($p<.05$).

FIGURE 2
Monthly Frequency of Suicide Attempts Among Southwestern Indians by Method



Although the Apaches constituted less than one-third (30.6 percent) of the study population, they accounted for over half (55.6 percent) of the INH overdoses. By contrast, the Pima tribe formed 22.4 percent of the study population and had only 5.6 percent of the INH overdose cases. For each tribe the frequency of INH overdosage paralleled the extent of INH usage.

Isoniazid had not been prescribed for 11 (30.6 percent) of the 36 Indians who had INH overdoses. Among the 25 overdose patients for whom INH had been prescribed, 17 (68 percent) were reactors, while the other 8 included 2 tuberculosis cases, 4 contacts, and 2 converters. The frequency of INH overdosage for each of the therapeutic categories paralleled the extent to which INH was prescribed for each group.

Figure 2 compares the monthly frequency of the suicide attempts for ingestions (INH or other substances) and for trauma. Only minor fluctuations occurred in the monthly rates for suicide attempts by trauma or by the ingestion of substances other than INH. However, INH overdosage attempts were significantly concentrated (27.3 percent) in July ($p<.01$).

DISCUSSION

Young adult Indians had the highest incidence of suicide attempts and completions, as has been reported by previous investigators (11–14). These Indians are beset with unusually disruptive conditions during adolescence and early adulthood (1, 11, 14). A constellation of discontent, disenchantment, and disbelief develops from various factors, foremost among which are the identity struggles of youth, stresses of acculturation, and doubts regarding the survival capacity and validity of the culture bestowed at birth (1, 14). These stresses are likely to be more severe among Indian tribes that were once nomadic hunters, such as the Apache, than among traditionally sedentary agrarian tribes, such as the Pima. For the former group, whose aggressiveness now is exhibited by accentuated self-destructive behavior, opportunities to develop positive social roles while constrained by the geographic and economic limitations of reservation life seem to be inadequate.

Dizmang and associates (14) have identified prominent features associated with high suicide potential among young Indians, including a history of multiple caretakers in childhood, frequent arrests within the last year (as well as initial arrest at an early age), intercurrent arrests of the caretakers, recent loss by desertion or divorce, and a history of boarding school attendance prior to the ninth grade.

In the present study the Indian women attempted suicide by ingestion more frequently than the men. However, in striking contrast to the Indian men, the women had a remarkable absence of any suicides by trauma, although both sexes made equal numbers of traumatic attempts.

The sharp peak incidence of INH overdosage for the month of July contrasts vividly with the lack of significant monthly variation in the patterns of Indian suicide attempts by trauma or by ingestion of substances other than INH. As a result of vacation from school, unavailability of employment, and lack of recreational activities, many young Indians are bored and frustrated in the summer. Furthermore, during July new physicians often replace experienced ones at IHS health facilities, and rapport is not readily transferred.

It is unlikely that the presence of INH in the household or Indian community led to suicide attempts that would

not have occurred otherwise. Similar age, sex, and tribal distributions occurred among the Indians with INH overdosage and the group that ingested other toxic substances. The Indians contemplating suicide apparently selected the most readily available acceptable method. Southwestern Indians have attempted suicide by ingesting toxic substances with increasing frequency during the past 15 years.

Indians who overdosed with INH were 10 times more likely to die than those whose suicide attempts involved ingestion of other substances. The probability that tuberculin reactors will develop clinical tuberculosis without treatment is approximately 1 in 1,400 per year (10). However, the Indians started on INH therapy had a risk of INH overdosage within a year of 12 per 1,000, and 1 in 12 INH overdoses was fatal (1 death per year per 1,000 patients started on INH). Thus, Indian tuberculin reactors had a similar degree of risk for developing clinical tuberculosis if untreated and for dying from INH overdose if given INH prophylactically.

Mental health professionals should be aware of the possible risk involved in INH prophylaxis in American Indians, especially among young women, of the relative contraindications to INH administration (high risk for suicide attempts and low risk for development of clinical tuberculosis), of the need for careful monitoring of patients receiving INH, of the desirability of good rapport between the patients and the medical personnel, and of the importance of controlling availability of INH, a potentially lethal drug.

The order of priority for INH administration (10) to prevent morbidity and mortality from tuberculosis is as follows: 1) clinical cases, 2) converters, 3) contacts, 4) previous cases that were inadequately treated, and 5) tuberculin reactors. Obviously, the possibility of INH overdosage should not deter treatment of patients with active tuberculosis. Nonetheless, precautions are indicated among persons at high risk for attempting suicide (young Indians, expecially women, and patients with a history of suicide gestures, alcoholism, or impulsive behavior). Rarely should persons at low risk for developing clinical tuberculosis receive INH prophylactically.

Measures to prevent INH overdosage include supervising drug administration with ambulatory tuberculosis chemotherapy (15) for selected cases, dispensing small amounts of INH at short (one month or less) intervals, frequently evaluating patient compliance with the prescribed drug regimen to deter any large accumulation, monitoring INH prophylaxis programs by paramedical personnel (16), and dispensing individually wrapped INH tablets to inhibit impulsive ingestion of massive amounts. Whether a paucity of reports of intentional INH overdosage in non-Indians relates to the lack of recognition or to the rarity of the problem is unknown; we suspect that the former is more probable.

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LETTERS TO THE EDITOR

Conundrum: Another Opinion

SIR: I would agree with Frank Bucknam, M.D., in his book review in the May 1975 issue that *Conundrum* by Jan Morris is indeed a fascinating book, especially in regard to what it says about sex-role stereotypes. Ms. Morris has been a victim of the sexist definitions of the "masculine" and "feminine" attributes of individuals. Although she comments on this at the end of the book, she does not seem to conclude that perhaps she would not have needed to go to such lengths if we had a more humanistic and androgynous value system.

Ms. Morris clearly saw womanhood as an escape from the dangers of "male" aggression. By being both male and female, she sought a double possession, a "heady sense of universality," a "quest for unity," a "more divine condition," and an "inner reconciliation." She had felt deprived of an identity as a young male because the stereotyped expectations were not comfortable and acceptable. More information on her childhood would be invaluable. One senses a resistance on her part, however, in the comment that she felt self-analysis to often be a mistake, leading one "down endless and unprofitable paths of speculation."

After she felt her conflict was resolved (by the sex-change operation), she began to feel free to notice the smaller, more intimate facets of life—perhaps by virtue of no longer needing to obsess about her sexual identity, feeling at last more acceptable as female. She cited "a sense of sacrament and fragility," noting that eternal womanhood "leads us above" (the baser male instincts?).

Ms. Morris is herself sexist, noting about women, "her fragility is her strength," "her inferiority her privilege." Her comments about penis envy are open to strong challenge from today's liberated women. Unfortunately, Ms. Morris seems to attribute intellectual powers to the male sex exclusively. She states, "I discovered that even now men prefer women to be less informed, less able, less talkative, and certainly less self-centered than they are themselves; so I generally obliged them." That statement is in itself more than unfortunate. It would be more beneficial if Ms. Morris integrated her past and present lives for sharing with humanity rather than (as she seems to prefer) obliterating the way she saw and felt as a man.

It is difficult to imagine how her family really felt about her sexual change, but there would seem to be no way in which a wife and four children could comfortably accept what happened, not solely in terms of the loss of a husband and father but, even more (particularly for the sons), the total rejection of a male identity.

This book seems most strongly to be a plea for humanistic values in society rather than the circumscribed and more traditional notions of male and female. Perhaps Ms. Morris's son Henry's quote says much of this all: "If a man can so innoculate himself with the idea he is not a man, but a woman, as to be to all intents and purposes a woman, that idea may in turn be made to give way to a higher ideal—that there is neither man nor woman."

BERRY BRACKETT, A.C.S.W.
Hartford, Conn.

Politics and Science

SIR: Upon the solicitation of my support for a prospective candidate's bid for APA office I sent the following reply, which may be of interest to *Journal* readers:

Dear _____:

I understand that you have contacted a number of colleagues, in addition to me, to ask our advice on your possible candidacy for presidency of the APA. I think I must withhold my advice for the following reasons:

In recent years I have watched with increasing concern the tendency to conduct campaigns for high office in some scientific societies along the familiar lines of political campaigns: organized sponsorship, mailings, solicitations of support, publication of sponsor lists, etc. (In one instance my name was used without my knowledge.) In some ways this is better than the selection of officers by small cliques with arbitrary power, but on the other hand it seems to me to be not nearly as good as the selection of scientific leadership solely on the basis of scientific distinction, leadership qualities, stated views on pertinent issues, and similar considerations. The main trouble with an organized campaign is that it gives more assertive and ambitious people an advantage over modest and retiring scientists, and it makes money demands which many worthy people could not meet.

I would therefore like to discourage all efforts at organized electoral campaigns that imitate the common practices of the political arena. Candidates should be selected either by formal nomination or by petition, their views should be published, and the membership should do the rest. If tradition and good taste do not restrain other practices, perhaps some formal rules of the game need to be made.

JOSEPH WORTIS, M.D.
Stony Brook, N.Y.

Social Disintegration in the American Community in Bangkok: Another View

SIR: I write in reference to the article by George Kojak, M.D., entitled "The American Community in Bangkok, Thailand: A Model of Social Disintegration" (November 1974 issue).

I believe it reflects poorly on the editorial policy of your journal to have published a discursive article such as this, with its many adverse comments on Thai society, without requiring from the author a more testable scientific hypothesis, one susceptible to documentation or proof. Dr. Kojak does make many accurate comments on the experiences of the American "official" community in Bangkok, but he is also guilty of many omissions, as well as some general biases, which I believe cast serious doubt on his judgment.

First, Dr. Kojak fails to mention that the International School of Bangkok (ISB) provides a stable social framework

for many American teenagers. Most American families with school-age children send them to ISB, which must be considered an integrating force and worth mentioning.

Second, Dr. Kojak refers to the lack of a "sense of mission or meaningful purpose" and to the "serious goals of Americans in Southeast Asia" in successive sentences. Surely this contradiction, which he has stated clearly, is largely responsible for the unease among the American community in Bangkok. Dr. Kojak has not identified the official organizations to which Americans are attached in Thailand, which include the U.S. Army, Air Force, and Navy, the Department of State, Department of Defense, the CIA, UNESCO, the Population Council, the Ford Foundation, the Peace Corps, the Smithsonian Institution, the U.S. Agency for International Development, and a variety of others. Is there any reason to expect that in 1971–1972 people representing such diverse groups should have shared a sense of common purpose or should have felt (or wished to feel) part of an "American Community"? Is there any reason to be surprised that parents and children in all these groups should have had doubts and conflicts of conscience over the U.S. presence in Thailand (and Southeast Asia generally) at a time when the war in Indochina was under increasing attack in the United States itself? Dr. Kojak totally avoided comment on the larger issues to which the American community in Bangkok was extremely sensitive. Rather, he implied that difficulties in negotiating a foreign urban culture were primarily responsible for the psychopathology found among Americans in Bangkok.

I am not denying the existence of psychopathology and social disintegration among Americans in Thailand (and I am not at all sure that the U.S. Army Hospital in Bangkok was adequately prepared to manage these problems). My main point is that as an American resident of Bangkok during the period 1969–1973 (as a staff member of the Rockefeller Foundation, an "unofficial" agency), it was my perception that the majority of problems among American families were due not to the "adverse circumstances" of life in Bangkok but to the inability of American families to adjust to any kind of cultural change or to cope with social demands that required something other than a supermarket, a push-button telephone, and an air-conditioned bedroom.

Dr. Kojak also did not mention language as a potentially integrating force. Those Americans who learn at least conversational Thai have found their lives considerably enriched by life in Bangkok.

The "PX culture" (there is indeed a large post exchange in Bangkok) and the tendency of official U.S. agencies to try to recreate the United States abroad are probably contributing causes of anxiety, unhappiness, and social distress among Americans in Thailand. It hardly seems fair to blame everything on the Thais. Moreover, the "R & R" atmosphere has been partly due to consumer demand on the part of U.S. servicemen flown in from Viet Nam for a week of uninterrupted pleasure seeking. Whose fault is that?

Most of all, I am distressed that *The American Journal of Psychiatry* has published an article which demonstrates very little, while arguing, both directly and indirectly, that Thai urban society is an evil force. I would urge the *Journal*, in recompense, to solicit a personal testimony from a Thai intern or resident at a hospital in New York City, inviting a statement as to how urban U.S. society disrupts and affronts the close-knit bonds among Thais living in the United States. Dr. Kojak might learn something.

MICHAEL M. STEWART, M.D.
Elmhurst, N.Y.

Dr. Kojak Replies

SIR: Dr. Stewart has misunderstood and misinterpreted my article and its theoretical basis. He draws conclusions based upon implications that have no basis in my article, offers subjective opinions that are not appropriate to scientific work, and—paradoxically—he contends with me on points upon which we both agree.

Alexander Leighton's hypothesis regarding the relationship of social disintegration to the prevalence of psychopathology already has much basis, which has been established by examining the factors of integration/disintegration of a community, measuring the prevalence of psychopathology, and comparing these with other communities. Leighton and associates' studies are widely regarded as classics in the field of psychiatric epidemiology.

Examining a society with a bias of what "should" exist, what one would "expect" to find, or with a judgmental, fault-finding attitude would, of course, have no place in scientific work. One attempts to describe what one finds, not what one wants to see. I do not feel I judged Thai society to be "evil"—unless Dr. Stewart believes that a culture which (compared to Western culture) does not emphasize work, regimentation, discipline, and regularity and does emphasize pleasure and good times with friends is evil. Dr. Stewart's statements appear to reflect this type of ethnocentric cultural bias. In several instances in which I described aspects of the city of Bangkok (not all of which necessarily represent traditional or usual Thai society), I leaned heavily upon the judgments and data of Thai professionals (as per my references). The studies regarding the changing social values in Thailand were done by a Thai anthropologist. The report on the prevalence of rabies virus was done by a group that included a Thai professional. The information and the opinions regarding the traffic problems were from another Thai professional—the Chief of the Traffic Division of the Metropolitan Police Department of Bangkok.

Dr. Stewart's meaning in his comment regarding the "serious goals of Americans" is not clear to me. My full statement was, "The serious goals of Americans in Southeast Asia were blurred and questioned." My point was that this situation probably *did* have much to do with the unease among the Americans, since it probably contributed to a lack of integration of the community. I felt that discussing and judging U.S. political and military activities and their effects in Southeast Asia beyond that statement in my article would have been discursive and probably less objective.

I would empathize with any Thai student who would come to live in one of the insecure, disintegrated cities of the United States and undergo the cultural confusion and alienation that is prevalent in some of them. It is almost trite to report that those metropolises (hardly "communities") have significant psychopathology. The Midtown Manhattan study by Srole and associates (1) documented this observation more than a decade ago. My article concluded as it began, with the idea of the American community in Bangkok as a dramatic model of social disintegration which could be applied generally and especially to American cities "that suffer from greater or lesser degrees of disintegration."

My American friends and I feel strongly that we learned of some of the most valuable parts of ourselves in Thai culture—the parts of openness, warmth, closeness, and pleasure. It is truly tragic that much of our own society appears to be quite stressed and threatened by such personal needs. Unfortunately there was no place in my article for such a discussion.

Finally, it strikes me as sad and ironic that this interaction between Dr. Stewart, who was with the Rockefeller Founda-

tion, and me—an ex-U.S. Army physician—may represent a continuation of the "suspiciousness and hostility" between the various organizations in Bangkok which I referred to in my article.

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GEORGE KOJAK, M.D.
Seattle, Wash.

Editor's Note: I plan to address questions of *Journal* selection procedures and editorial policy such as those raised in Dr. Stewart's letter in an editorial in a forthcoming issue.

Recognizing Somatopsychic Symptomatology

SIR: John Gatewood, M.D., and associates in their article "Mental Changes Associated with Hyperparathyroidism" (February 1975 issue) brought to mind the importance of detecting somatopsychic phenomena. The mental changes and behavioral manifestations secondary to organic disease can be so dramatic that they overshadow the primary source of illness in adults as well as children and adolescents.

For example, several years ago a 14-year-old girl was referred for psychotherapy by the guidance department of her school because she was obnoxious, undisciplined, hyperactive, quarrelsome, and inattentive in class. The parents reported that her behavior at home had deteriorated in the previous 6 months and that she was extremely touchy, suspicious, and a "pain in the neck." The change in her personality had occurred both in school and at home in a relatively short period of time. In the written report that I received prior to seeing her, it was also stated that she constantly opened the windows at home and at school, even though it was winter at the time. The mother complained that the patient ate voraciously and without concern for other people in the family.

The patient was tall, thin, and agitated. Her speech was rapid and her eyes bulged. Her pulse was racing (180 a minute), and there was a noticeable tremor of her hands. Laboratory tests confirmed severe hyperthyroidism. Medication alone did not suffice and she required surgery.

Postoperative follow-up showed an excellent adjustment and return to premorbid behavior and function. There was no need for psychotherapy other than a few sessions with the family to help put things in perspective.

I believe that psychiatrists must always be aware of somatic illnesses as a possible etiological factor in mental disorders as well as in behavioral difficulties in children, adolescents, and adults. This is why I oppose the abolition of the internship for future psychiatrists. I believe that a medical internship provides a clinical experience which can make a significant difference in the psychiatrist's diagnostic skills.

LEON TEC, M.D.
Norwalk, Conn.

On the Advantages of Private Practice

SIR: I was pleased to see the article entitled "Private Psychiatry and Accountability: A Response to the APA Task Force on Private Practice" by Steven Sharfstein, M.D., and associates (January 1975 issue). Although I agree with the conclusions set forth in that article, it seems to me that more should be said concerning the advantages of the private practice of psychiatry.

My average case load over a 10-year period of full-time practice has been approximately 300 patients—the same as that reported in the task force report. I am presently charging $40 per hour of patient service. The best of the public outpatient clinics in this area have a case load per professional that is approximately one-third of mine, and their costs per patient hour are more than twice what I charge. The task force report cited four failures of the private sector—but the public sector of psychiatry had made no further progress to solve these failures of patient care. I therefore wish to stress the conclusions of Dr. Sharfstein and associates that "it is premature at this time to assert the superiority of private care over public care"—a possible exception to this being the areas of cost and personnel efficiency.

RONALD A. SHELLOW, M.D.
Miami, Fla.

Research on Chinese Health Care

SIR: I was pleased by the appearance in the *Journal* of "Psychiatric Training and Practice in the People's Republic of China" by Philip D. Walls, M.D., and associates (February 1975 issue). There is no doubt that China offers important alternatives to Western definitions and treatment of mental illness. Most of the firsthand accounts of visits to China by U.S. medical personnel published in the past three years have been limited to descriptions of visits to China's major cities and larger institutions. As I have suggested elsewhere (1), it is now appropriate to venture beyond these descriptive accounts to a more basic analysis. The middle and lower levels of the health care system and the cultural, social, and political variables relevant to the definition and treatment of mental illness remain largely unexplored. I wish to describe three areas I consider crucial.

First, although the Chinese medical care system emphasizes primary contacts at the periphery of the system, these are the areas about which we know the least (with the exception of descriptive material on the "barefoot doctors"). We lack studies of pathways to treatment and referral within the organization with reference to mental illness.

Second, while it has been stated (by Walls and associates and others) that no one consistent theory of mental illness is accepted by the Chinese, the boundaries between their conceptions of types of deviance—criminal, political, and psychiatric—have not been explored. Analysis in this area should center on the influence of current conceptions of deviance on the actions of professional groups and the general population.

Third, we know sadly little about the mental health of the vast majority of Chinese, who have no contact with the few trained mental health workers. Data have related to the eradication of certain forms of mental and social pathology (e.g., drug addiction and prostitution) and to the diagnosis and treatment of the severely ill. China is a particularly interesting case because of its policy of intense social integration and political awareness and its continuing social and cultural revolution. One possible study would be an application of our current literature on life events and symptomatology to segments of Chinese society undergoing relocation from urban settings to the countryside.

Restrictions on travel and on access to records make it difficult to study China. However, many American authors have acknowledged the cooperation and interest of the Chinese in their

research. Future visitors should carefully define researchable topics in order to obtain the most broadly relevant and analytically sound information on the fascinating People's Republic of China.

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SYLVIA K. NIELSEN, M.A.
Farmington, Conn.

Putting a Stop to "Wizardry"

SIR: Judge David L. Bazelon's timely paper, "The Perils of Wizardry" (December 1974 issue), provides us with a unique opportunity to find out how our profession looks through the eyes of a distinguished and perceptive lawyer who has long watched us closely, and to compare his perception with our self-image. (Periodic catharsis is supposed to be good for the soul.) It is not surprising to me that the look from up there does not quite correspond to what we would like to believe and to what we see down here.

It is my impression that the statement "Most psychiatrists did not acknowledge the limits of their expertise" is a generalization which may apply to a relatively small group of psychiatrists who find their gratification in pursuit of activities outside the traditional medical model. If we occasionally do serve "to weed out the 'undesirables' from government and industry, the 'troublemakers' from the schools, the 'character disorders' from the mental health centers, and the 'disciplinary problems' from the military," we do so because everybody else, the courts included, appears unwilling or incapable of performing this function. Almost every psychiatrist I know agrees that we may not be very efficient at or best qualified for this job, but the job has to be done. Putting the terms in quotation marks does not make the problem disappear.

Similarly, I hope most psychiatrists are sensible enough to acknowledge their lack of expertise in combating inflation, unemployment, or poverty. These are roles of our duly elected officials. We should have no difficulty in the courts if we stick to the facts and refrain from making "interpretations." Where we failed most miserably was in presenting the public with a sensible description of what psychiatry can and cannot do.

With this lack of limit setting, the field became wide open to new therapies providing new cures for old ills, which the public bought with great expectations. Needless to say, the expectations did not materialize. The stage for the Wizard of Oz image was set a long time ago.

What we need to do now is to take off the wizard's hat and return to the language of facts. Mental illness is increasingly recognized as being caused by biochemical or structural disorders of the brain. As such, it cannot be cured by manipulating the environment, changing the social system, or providing a minimum income. It can be made more bearable, less visible, and less tragic, but it cannot be cured. I don't know if we should tell the public this. It might take away the illusion of hope and weaken the will to fight and endure. But this I know; if we don't tell it, we will always suffer from the accusation that we resemble the Wizard of Oz—either stupid or bad or both.

JANUSZ JOHN GARWACKI, M.D.
Austin, Tex.

On the Moon Again

SIR: Alex D. Pokorny, M.D., and Joseph Jachimczyk, M.D., in "The Questionable Relationship Between Homicides and the Lunar Cycle" (July 1974 issue), criticized the methodology of a study I coauthored (1) and then presented findings of a similar study they conducted. Since they were unable to demonstrate a statistically significant lunar periodicity in their data, they concluded that "the effect of moon phases on homicide, suicide, and mental illness should be viewed as a myth."

The method of time-window analysis that we used is a simple mathematical comparison between cases occurring during a given time period on either side of a specified time point (a lunar phase instant in this case) and the remainder of the cases occurring during the rest of the lunar cycle. Hence, we did indeed look at the lunar month as a whole. The lunar phase interval scale was carefully designed to avoid contaminating lunar time with known solar calendar periodicities such as variations related to season, time of day, etc. That we accomplished this was proved by Drs. Pokorny and Jachimczyk when they tested for the possible influence of known high- and low-homicide hours on their data distribution. They found that cases occurring only during daily and weekly high-homicide times (solar periodicity) were evenly distributed throughout the lunar cycle over any long period. They questioned our assignment of the time 12:00 noon when the day but not the precise hour of injury was known. Because our aim was to keep within a lunar time frame, the hour is irrelevant since the case will fall within either the appropriate lunar phase interval or the adjacent one on either side no matter what hour is selected. Time-window analysis therefore assures that the statistical comparison will be unaffected.

I would like to comment on Drs. Pokorny and Jachimczyk's methodology. The validity of any scientific study depends on the accuracy and appropriateness of 1) the variable being measured and 2) the tools used in the measurement. It is reasonable to use time of injury as the variable when one measures the occurrence of violent events—Pokorny and Jachimczyk's use of time of death is not justified by their supposition that 85 percent of Houston's homicide victims die within one hour after injury.

A 15 percent error that is always in the same direction (death is always later than injury) would certainly affect the frequency distribution in these data. In order to test this, we reevaluated our own data using time of death. We also retested the Ohio data and analyzed a sample of New York City homicides (over 8,000 cases) using this variable. Overall chi-square tests on each sample showed no significant variation among lunar phase intervals from the frequency expected by chance. In other words, when measured according to lunar time, violent injuries show a lunar periodicity, but deaths are distributed randomly throughout the lunar cycle.

Pokorny and Jachimczyk's statistical approach is somewhat puzzling. The overall chi-square test indicates whether at some point in time the frequency deviates significantly from an expected value, but this test is not sensitive enough to test the significance at any given point (i.e., it should not be used to test peaks on a curve). I do not understand the rationale for their use of correlation coefficients, which are useful only in measuring the tendency of two different curves to rise and fall together. We have never claimed that homicide curves from different cities parallel one another. If anything, our findings imply that the curves would be expected to differ on the basis of geographical location (2) and other factors.

The opinions of Drs. Levy and Pokorny (3) notwithstanding, investigating the possible influences of the natural geophysical environment on human behavior is a serious matter. Dr. Sherin and I had hoped that our paper would stimulate

high-quality objective research in an area long a subject of scientific controversy. Much work is now being done, and more is required before we will find useful answers.

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ARNOLD L. LIEBER, M.D.
Miami, Fla.

Training Psychiatrists To Care for the Elderly

SIR: "The Psychiatrist's Involvement with Aged Patients" (January 1975 issue) by Floyd K. Garetz, M.D., is an interesting contribution to our understanding of why it is that although many elderly people in the United States experience mental and emotional disorders, the elderly as a group seem to underutilize psychiatric services. There are many reasons for this phenomenon. Dr. Garetz implies that some of them may be found in factors influencing psychiatrists' attitudes toward the aged, one of which is the limited or nonexistent attention given in medical school curricula and in psychiatric residency training programs to the psychological and psychiatric aspects of later life.

The Bronx-Lebanon Hospital Center is attempting to remedy this situation in the clinical clerkship in psychiatry offered to students from the Albert Einstein College of Medicine. The clerkship, which uses recent texts (1, 2) and includes field trips to long-term care facilities for the aged, provides medical students with a unique opportunity to become familiar with the special medical and psychiatric problems of the elderly. The students' interest in this segment of our population has increased proportionately.

If programs such as this were adopted more generally, a significant barrier to the appropriate utilization of psychiatric services by the elderly would be removed.

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SEYMOUR B. JACOBSON, M.D.
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The Bronx-Lebanon Hospital Center
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Dealing with Dying Patients

SIR: I would like to comment on Dr. Peritz Levinson's aptly titled article, "Obstacles in the Treatment of Dying Patients" (January 1975 issue). It is a truism that many of the obstacles to any type of psychotherapeutic treatment lie within ourselves rather than our patients. Treatment of the dying patient is no exception. If Dr. Levinson practiced his excellent precepts, he would find fewer obstacles. However, there is ample evidence in his article that he neglected at least two of the most important.

First, Dr. Levinson stated, "It is particularly urgent that the psychiatrist establish rapport with the primary care physician. . . ." Does the psychiatric consultant contribute to this rapport by accepting referrals from the nursing staff rather than from the physician? Isn't it more conducive to rapport with both physician and patient to accept referrals only from the physician? Couldn't nurses be requested to tell the patient's physician of their concerns and to ask him to request psychiatric consultation? Shouldn't the patient's physician, rather than the nurse, inform the patient that psychiatric consultation has been requested, and why? How would Dr. Levinson feel toward the internist who examined and treated his hospitalized patient without first obtaining his consent? Shouldn't the physician who is responsible for the patient's care be given the opportunity to refuse the services of a psychiatric consultant? Isn't refusal of psychiatric consultation appropriate in instances where patients may have been, as Dr. Levinson reports, "referred by the nursing staff because they were not experiencing the level of feeling associated with fatal disease"? I wonder what that level of feeling is—despair? Patients were referred "who manifested stoicism. . . ." Is stoicism pathological?

If it is true that "pathological defenses usually must be supported rather than challenged," what advantage to the patient is there in treating a 61-year-old truck driver who is dying of metastatic carcinoma who "employed massive denial toward his fatal disease." What does the therapist have to offer him that is superior to his "total denial of a sense of . . . inferiority" and "ongoing and grandiose monologue of former physical strength, emotional stability, and vocational feats"? Was this patient projecting or being paranoid when after being referred for psychiatric consultation by his nurses he viewed physicians as "sadistic, negligent, and inadequate?" Was he unrealistic because he was overwhelmingly resistant to any behavioral consultation, whether it was from a nurse, social worker, or physician, or because he felt suspicious of all educated people and of anything that seemed at all intellectual? I think he had an excellent reason for these attitudes.

Discussion by the medical and nursing staffs of their attitudes toward psychiatrists will not help if they correctly perceive that psychiatrists are more harmful than helpful to the comfort of dying patients.

I would like to add one suggestion to those offered by Dr. Levinson. The foundation for the ability to recognize and respond to the emotional needs of patients who are terminally ill can only be acquired at the bedside during the experience of being the physician who is responsible for their care.

Dr. Levinson states we must influence "official attitudes" to improve the care of dying patients. Unfortunately, he is again looking outside the purview of psychiatry for the cause of the impediments he met. One "official attitude" we must influence is that of the American Board of Psychiatry and Neurology, which in August 1974 decreed that four months of nonpsychiatric clinical experience are enough for a medical student to grow into a physician.

LEWIS GLICKMAN, M.D.
Brooklyn, N.Y.

Dr. Levinson Replies

SIR: Dr. Glickman's stimulating critique focuses on two main points. The first is that the failure to go through traditional channels of referral undercuts rapport with the primary care

physician and that this, rather than the patient's psychopathology, contributes to obstacles in treatment. I have two responses.

First, the surgical service is a more acute one and the nurses spend more time with patients and work in more crisislike situations. Their work is directly affected by the consequences of psychopathology in a patient, such as lack of cooperation or apathy, and they freely seek help from the psychiatrist. Once a problem case is identified, the attending physician is consulted and included in the learning process.

My second response centers on the blurring of roles in contemporary medical care. Nurses are beginning to be regarded as members of a team rather than subordinates in a heirarchy. In no instance I reported did the attending physician resent the fact that the nursing staff initiated the referral. In fact, these referrals led the surgeons to become more aware of psychiatric complications and better able to detect them in their patients.

Dr. Glickman asks whether a patient who is faced with the overwhelming reality of death suffers less by having mental health care than by being allowed to retain such defenses as denial and withdrawal. Is the gain worth the pain of giving up defenses and confronting reality? It is important to emphasize that each problematical dying patient must be carefully evaluated as to his/her capacity to confront adversity and need for denial. Some patients will have to retain all of their defenses, but even these individuals can often be helped by understanding without intervention. Moreover, the patient's need for denial is often coordinated with the doctor's need for denial. Whether they are explicitly told their prognosis or not, most patients are aware of it. They are eager to not have to face their illness within the isolation that is mandated by schizoid and paranoid defenses. The dying patient wants to be helped from his state of inner panic and desperation to one of acceptance and calm, although it will be appropriately sad. Kübler-Ross's conclusion that a majority of patients can be helped to "die in the stage of acceptance, an existence without fear and despair" (1) has often been confirmed in clinical practice.

Finally, I agree with Dr. Glickman that the physician's bedside experience is of prime importance in refining the management of the terminally ill patient. However, here (as in any area of medicine) the doctor's effectiveness is also dependent on advances in the science.

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PERITZ LEVINSON, M.D.
New York, N.Y.

A Response to the Doomsayers

SIR: After listening to much talk and reading recent contributions on the subject of recertification for psychiatrists (and other specialists), I find myself again and again reminded of what seems to be a developing (or galloping?) consumption of the professional spine and backbone—not to mention professional pride—within our specialty and some of its representatives. I am getting very tired of the monotonous alarmist outcries concerning our alleged failure to respond to what are called "obvious social and political pressures" and of statements to the effect that if we do not do it (i.e., recertification and relicensure) ourselves, others will do it for us.

Not so! Those who think they can "do it for us" are wrong. Bureaucrats, politicians, consumer advocates, etc., cannot treat patients with psychiatric problems, as they would discover very quickly (so would any of our critics if he/she were to develop some mental disorder).

The crux of the matter is not the impending death of psychiatry projected by questionable self-appointed prophets or a failure to respond to obvious social pressures (which I often find highly nebulous and debatable) but the continuing need to develop more rational data and basic research in order to make our specialty less of an art and more of a teachable science.

F. PAUL KOSBAB, M.D.
Northport, N.Y.

Back on the Boards

SIR: The article "How To Avoid Taking the Boards but Save Face" by Daniel Y. Patterson, M.D. (January 1975 issue) is a good example of what it takes to pass the American Board of Psychiatry and Neurology exam: say what you want, but be certain it is acceptable to the board of examiners. Examinees need not go so far as to take an oath that they believe what Dr. X had to say about this or that—they merely have to recite it all, because the examiner happens to like Dr. X's comments (even though they are probably irrelevant to patient care and to the individual's own special interests). Deviants must be careful—so must those with new ideas who are too busy to play "Guess what I am thinking now." Other than canine pedigrees, I can think of no area where credentialism is so meaningless.

With all the unsatisfied needs extant in our society, it is insulting and abhorrent to waste one's time preparing to play parrot for the Board examiners: there is too much to do and learn in accordance with one's own personal wishes and aims.

The assessment of patient care capability in the Board examinations is unsatisfactory. Current methods appear to be artificial contrivances and in vitro alibies to prevent a few from passing the Boards. In reality, only patients and their families know what good any of us are, regardless of the prognostications of the elite.

I will provide a confirmatory example: a colleague of mine studied intently for months but did not pass the Boards—and he was and is an excellent clinician, a better teacher, and an innovative thinker. When he did not pass, I realized more than ever that the whole Board mystique was another Freudian, pseudoscientific fiction, a comedic "our gang" rendered important only because some are excluded.

A final issue in taking Boards relates to personal conscience. There are some individuals (a minority of at least one) who no longer want to belong to any organized agency of science. For us (or at least me), the Board is indeed intolerable because it is part of the American scientific establishment, which has brought about a degree of death and destruction of human and nonhuman creatures that far surpasses that caused by all other groups in the history of man. Without an allegiance to life, any group (regardless of its successes) becomes merely another terrorist organization with the "thanatismo" attitude not only sanctioned but, in some cases, authored by psychiatry.

To call the current era anything other than a scientific Inquisition is to be mentally blinded by the most primitive of psychological mechanisms. Nowhere is the Inquisition more evident than in the necessity to take psychiatric Boards and recite what the examiners want to hear.

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BOOK REVIEWS

Guide to Psychiatry, *3rd ed., by Myre Sim, M.D., D.P.M. London, England, Churchill Livingstone (New York, N.Y., Longman, distributor), 1974, 1,191 pp., $21.00.*

Myre Sim describes this third edition of his British text as "a considerable improvement on its predecessors." Had the previous editions been poorly written or badly researched, this statement would not mean very much. However, they were excellent works, and this one is still a considerable improvement.

It is some index of the progress of psychiatry in the past two decades that a textbook can contain 1,133 pages, plus references and index, without excessive verbiage and, indeed, without seeming particularly massive. Sim takes particular note of the changing role of psychiatry in modern medicine and observes that he has tailored his book accordingly. Despite its length, Sim views his work as a "handy benchbook" that can and should be supplemented by the liberal supply of references.

Sim demonstrates clearly how the British have earned a reputation for first-class medical writing. The prose is not lyrical or pretentious; it is simple and straightforward and free of jargon. If there is any disappointment for the reader, it may be that there are too many citations from other authors and too little of Myre Sim. This is particularly tantalizing because those observations he does make are so often provocative.

In the conclusion of his chapter on "Psychopathic Personality," for example, Sim says,

> Modern society has many disagreeable tasks and one is the humane rehabilitation of the psychopath. It frequently turns to the psychiatrist for help but all it receives is an acceptable formula. Whether it works or not does not appear to cause society much concern but psychiatrists should carefully assess their competence in this field and if they are satisfied that they have no competence they should say so and direct their energies into those fields where their work is of proven value. This does not mean that there should be no experiment. It does mean that it was premature to legislate before the factual information was available. (p. 448)

Similarly, in "The Psychopathology of Research," he observes,

> There is an increasing tendency to transfer the interpretations of psychopathology from the field of clinical psychiatry to social situations, such as the political field, or to interpersonal relationships. While this may prove a satisfying exercise for the practitioner and permit him to score against his adversary, it can have overtones which are not only undesirable for the field in which they are used, but can contribute to undesirable changes in society itself. (p. 68)

Sim obviously foresaw, before many of us, the increasingly complex interweaving of psychiatry and the law. In recognition of that fact, he has provided not one but two chapters on "Legal Aspects of Psychiatry." One discusses the state of affairs in Great Britain, and the other, written by John Donnelly of the Institute of Living, reviews the same topic from the American point of view. Taken together, these twin chapters are a special highlight of a book with many highlights. Sim and Donnelly have perceived that forensic psychiatry is much more than a listing of laws, rules of evidence, or court decisions. It is a mirror—sometimes distorted to be sure—of our society and its attitudes toward human behavior.

The psychiatrist is occasionally oppressed by the plethora of textbooks, each with its own special merit and each bearing some stamp of the author. This one ranks with the very best and is worth every penny of the price.

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Themes and Variations in European Psychiatry: An Anthology, *edited by Steven R. Hirsch, M.Phil., M.D., and Michael Shepherd, D.M., D.P.M. Charlottesville, Va., University Press of Virginia, 1974, 429 pp., $20.00.*

Differences between European and American psychiatry have often led to semantic or practical misunderstandings. The differences are not only in terminology but in the delineation of nosologic entities and even in basic concepts. This book attempts a much-needed clarification. It contains translations of about 20 papers from European psychiatrists, mostly French and German.

A few among these papers are of mainly historical interest. Such is Kraepelin's "Comparative Psychiatry" (1904), a founding stone of what is now called transcultural psychiatry. There is also Ganser's original description of "a peculiar hysterical state," now called Ganser's syndrome, and Gaupp's summary of the case of Wagner, a paranoiac mass murderer, which includes an exhaustive anamnesis and a 24-year follow-up.

More directly relevant are those papers of methodological, conceptual, and epistemological interest: Kraepelin's discussion of clinical research in psychiatry, Jaspers' famous distinction of causal "explaining" and empathic "understanding," Birnbaum's no less crucial distinction of the "pathogenic" and "pathoplastic," Conrad's views on how to apply Gestalt principles in psychiatry, and those of Kurt Schneider on the concept of delusion and on primary and secondary symptoms in schizophrenia. The concept of psychogenic reaction is discussed by Bonhoeffer. It would also have been appropriate to include Jaspers' distinction of "process" and "faulty development" (*Fehlentwicklung*).

Papers devoted to the etiology of mental diseases represent a third group. Among these are Gjessing's summary of his clinical and biological findings in periodic catatonia, Dupré's theory of "cenesthopathia" (disorders of subjective experience related to troubles of general bodily sensations), Strömgren's concept of psychogenic psychoses, Kleist's distinction of "typical" and "atypical" psychoses, and Sjöbring's theory, little known outside Sweden, which explains mental disorders by means of a system of four characteristic features pertaining to the mental activity of the individual.

In the fourth group are those papers devoted to clinical, descriptive psychiatry. European psychiatrists are more prone than their American colleagues to distinguish among acute mental conditions those of organic and psychogenic origin. This accounts for the interest of Bonhoeffer's paper in exogenous psychosis and of a number of French authors in the *bouffées délirantes*. A good deal of what Americans would include in chronic schizophrenia is called "systematic chronic delusions" by the French and divided into various nosological entities. Nihilistic delusions are described by Cotard as a specific illness occurring as a complication in severe melancholia. French psychiatrists have also been concerned with finding out the various mechanisms involved in chronic delusions. De Clérambeault's concepts of *délire passionnel* and the delusions based on "mental automatism" are expounded in this volume, the former by Baruk, the latter by Nayrac.

This section of the book could have been more complete if the editors had also referred to Sérieux and Capgras's concept of *délires d'interprétation* and to Dupré's *délires d'imagination*. Kretschmer's idea of "sensitive delusion of reference," paranoiac delusions as the slow progressive interactions of a "sensitive" makeup and specific life situations, also belongs here.

Hirsch and Shepherd's anthology, besides being a most valuable sourcebook, is a timely contribution to the efforts being made nowadays to establish a universal psychiatric frame of reference.

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The Death of Psychiatry, *by E. Fuller Torrey, M.D. Radnor, Pa., Chilton Book Co., 1974, 228 pp., $8.95.*[1]

What can one say about a book by a psychiatrist possessed of manifest intelligence, erudition, and literary skill, yet written with such bias, misrepresentation, illogic, and sophistry that no informed reader can peruse it without regretting that colleague's misuse of a trusted position? Although the title page of this book notes that "the opinions set forth in this volume . . . do not represent the policy of the National Institute of Mental Health or the U.S. Public Health Service," this hardly balances the display of Torrey's official appointments on the book's jacket.

Torrey implies that because psychiatrists use such terms as "melancholia" and "hysteria," they must believe that the former is caused by an excess of black bile and the latter by a wandering uterus. Had Torrey consulted contemporary sources (1–3), he would have learned that even Greisinger and Kraepelin were fully aware of the direct relevance of individual and social dynamics in the etiology of deviant behavior.

Torrey dismisses psychoanalysis and behavior therapy in two half-pages each. Group, existential, Rogerian, transactional, and other modalities are allotted a few sentences. All are merely "different brands of toothpaste," valid only insofar as they may be unintentionally educational. Especially horrifying to Torrey is sex therapy, which he presents as if it were as widely condoned and practiced as are most of the other therapies he mentions.

Torrey agrees with my own definition of the word "mind" (4, 5) as a verb denoting the processes of attention, stored experience, and adaptation rather than as a noun. Unfortunately, he then proceeds once more to confuse "mind" as an abstraction for experientially determined conduct with "brain" as a neural substance. Torrey also seems unable to sense the hyphen implicit in the word "dis-ease" as literally implying psychologic uneasiness as well as physical discomfort.

Torrey proceeds to the following partially justifiable attack on *DSM-II* (6):

> [It is] a nosological mishmash [of undefined] etiology, . . . intelligence levels, . . . personality traits, . . . age, . . . sexual choices, . . . deviated affects, . . . drug intake, . . . [and] legal responsibility. (p. 43)

In ostensibly stark contrast, he states,

> A bacteria [sic] which causes pneumonia, a fall which causes a broken leg, a deposit of fat which causes a heart attack . . . provide the basis for classifying [true] disease. (p. 43)

According to this monothetic approach, whether or not a patient continues to expose himself to infections, walks carelessly, or overeats has little relevance to prognosis or comprehensive therapy.

Torrey avers that holding mental patients not responsible for their behavior leads to their losing self-esteem and a Pandora's box of social confusions that would have "discredited . . . Jesus . . . as hallucinated and delusional." Medvedev, Ezra Pound, and Gen. Edwin Walker are then classed with Jesus as having also been deprived of their "right to trial."

Further generalizing from alleged legal abuses that even the American Bar Foundation considers rare (7), Torrey asserts that because of court decisions based on psychiatric examinations "lasting only a few minutes," 350,000 individuals are now involuntarily confined in mental hospitals. Paradoxically, Torrey then laments that if the precedents of the M'Naghten rule, the 1954 Durham rule, or even the new concept of "lack of capacity to judge" were fully applied, all criminals would be held not responsible and set free.

Torrey believes that the only valid model for preventing "true disease" was set by John Snow, who capped a London well in 1849 to eliminate the "sole source of a local outbreak of cholera." (This was actually done by the Board of Guardians of St. James Parish.) By implication, we can regard as irrelevant René Dubos's brilliant elucidation (8) of the role of deprivation, overwork, ethnic stresses, war, and many other psychological and social factors in the etiology of even infectious diseases.

Torrey states that "schizophrenia is . . . a brain disease and not caused by a cold, rejecting mother, an unresolved Oedipus complex, or ambiguous messages"; rather, it is an "affliction to be treated only by neurologists" (p. 158). Therefore, "When suicide is put in its true perspective [as not a brain disease] the concept of 'sick' loses meaning altogether." Ergo, suicide is not in the province of neurologists, let alone psychiatrists, social workers, or, apparently, anyone else.

In the Utopian future, according to Torrey, "clients" (not patients) will voluntarily enter "retreats" (not hospitals) where they would be governed only by their own rules, although they would be "obligated . . . to help . . . others." The issue of health insurance would be solved by having all retreats supported by the state, since "three quarters of the problems of living would not be covered any more than is unhappiness on a rainy day" (p. 173). Budgets would then be further reduced by having suicidal patients select "tutors" who would agree that any person who wants to kill himself has the right.

[1] A more detailed review of this book can be obtained from Dr. Masserman at 8 S. Michigan Ave., Chicago, Ill. 60603.

But because many people who attempt suicide, as well as their families and friends, live to regret this act, modern jurisprudence usually frowns on self-destruction. So the law, too, is "a field whose current methodologies have produced the near bankruptcy of justice . . . and only more criminality."

I recognize Dr. Torrey's abilities, sincerity, and professional courage, and I concede that he may stimulate some rethinking and reform in psychiatry. I, too, have written on the need to revise our outmoded diagnostic system, review and integrate our welter of therapies, and clarify our roles vis-à-vis the fields of anthropology, history, education, sociology, and jurisprudence. But I have tried to be constructive in these critiques rather than hostile to my chosen specialty (4, 5).

Finally, I feel no defensive need to rehearse the many theoretical, therapeutic, and social achievements of modern psychiatry. Nor need I further deplore Torrey's Viet Nam war solecism, "To save our field, we must destroy." Iconoclasm of false images is occasionally permissible, and valid criticism is welcome, but vandalism is not. I recommend to Dr. Torrey deeper reflection to the effect that, however still imperfect our specialty, the behavioral sciences, Torrey's colleagues, and the public deserve far better service than he renders in *The Death of Psychiatry.*

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Normality: Theoretical and Clinical Concepts of Mental Health, *revised ed., by Daniel Offer and Melvin Sabshin, with the assistance of Judith Offer. New York, N.Y., Basic Books, 1974, 255 pp., $8.95.*

This book is a revised edition of a predecessor with the same title published in 1966. The first section of the revised version, titled The Disciplines, includes chapters on "Medical-Psychiatric Thinking and Gross Normality," "Epigenesis of Normal-Neurotic Behavior: Psychoanalysis," "Normative and Ideal Concepts in Psychology," "The Cross-Cultural and Cross-Societal Perspective," and "The Structural Perspective in the Biological Sciences." These chapters have been modified very slightly from the 1966 edition and remain a historical introduction for the second part of the book, titled The Emerging Trends.

Chapter 6, "The Four Perspectives of Normality: A Synthesis," and chapter 7, "Ethics, Aesthetics, and Normality," are very important transitional chapters. I found chapter 6 especially well conceptualized and well organized. Here the authors discuss the four perspectives of normality in detail, i.e., normality as health, as Utopia, as average, and as transactional systems.

The greatest revision in this edition is seen in chapter 8, "Empirical Research on Normality: A New Look," and chapter 9, "Toward an Increased Understanding of Normality and Mental Health." In their summary of chapter 8, the authors introduce the following theoretical possibilities for the use of the data collected:

> 1. The compilation of all the criteria and extraction of certain commonly occurring items that could be regarded as the core of normality.
> 2. The compilation of all these studies and the considerations of each as exemplifying a different aspect of one holistic definition of normality.
> 3. The separate consideration of each definition of normality as valid within the circumstances that were particular to its derivation. (p. 159)

In discussing the first possibility, they observe that the conclusion is ideal but that there are no acceptable criteria for normality. The authors believe that a ray of hope is present in the second proposition but that more research is needed before the hypothesis can be tested. They state that according to the third position, "it is possible that definitions of normality will never serve . . . to make 'normality' a singular rather than a plural term" (p. 160).

The authors state that their aim is to offer an "analytic" approach to the problem of identifying normality. I believe that they succeeded admirably in this endeavor. For those of us who are continually confronted with one form of psychopathology or another, it is very refreshing to stop and examine the opposite end of the continuum.

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The Meaning of Criminal Insanity, *by Herbert Fingarette. Berkeley, Calif., University of California Press, 1974, 265 pp., $3.25 (paper).*

The back cover of this paperback quotes praise from Prof. Sanford Kadish of Berkeley and Abraham Goldstein of Yale as well as an accolade from Dr. Jonas Rappeport, Chief Medical Officer, Supreme Bench of Baltimore. The book is an impressive endeavor by a well-trained mind operating in the mainstream of contemporary forensic thought about criminal responsibility. Unfortunately, this mainstream of thought runs profoundly astray and, therefore, so does Professor Fingarette in this book.

In an admirable summary of the long-standing confusion about criminal responsibility, Professor Fingarette recognizes that there is something very wrong in this field. He quotes several others who have noted the chronic vagueness and lack of analysis of fundamentals that characterize its literature. Professor Fingarette rejects superficial solutions and insists that an underlying rationale must be developed. However, he then proceeds to accept "intuitive" conceptions about what criminal responsibility is, never attempts a precise definition of it, and, without further analysis, proceeds to center his attention on clarifying the concept of criminal insanity. This is a fatal error because there is little prospect of getting the concept of criminal

insanity straight until we have a precise definition and explicit rationale of criminal responsibility.

What Professor Fingarette accepts intuitively is the judicial process of moral judgment of the accused. This places him on the side of the angels and jurists. It is not long before psychiatrists are discovered to be living in sin in their ghetto of natural events, obstructing the smooth operation of the courts with their naïve and intractable views about mental illness and behavioral causation. Dragged into this cosmic business of moral judgment of individuals, the psychiatrists have been virtually defenseless, their hapless gropings providing plenty of footnote fodder for unjustified scolding.

Since man is the only entity in the universe subject to moral judgment, we might well be suspicious that this ancient preoccupation is the source of the unique difficulties attending criminal responsibility. Committed to the moral judgment of individuals, Professor Fingarette flounders around in a swamp of metaphysics, trying to stay afloat with the skillful strokes of a philosopher.

In need of a legal reality separate from natural causation, he seeks it in the careless teleology that mars a great deal of psychiatric theory, derives it by implying that diverse levels of discourse entail diverse realities, imports it from the ontological confusion of Platonism in a chess-versus-physics analogy, and generally, like a conscientious lawyer saddled with an indefensible case, embarrasses his best ploys because there is no way to invest our courtrooms with a reality other than the behavioral realism of science.

When Professor Fingarette finally formulates his concept of criminal insanity, he opts for emphasis on irrationality of motivation as well as cognition. Why the irrational motives of the psychopath, thinly veiled by his mask of sanity, do not qualify as criminally insane remains unexamined. Nor is it explained why such perverted acts as sadistic murder, as irrational in their way as the paranoid delusions of M'Naghten, seldom exempt the perpetrator from criminal responsibility.

The basic failure here is the lack of an explicit, naturalistic, and precise rationale as to just why irrationality, mental illness, or even childhood has anything to do with criminal responsibility. As the last sentence of this book states, "Without clarity on the principle, all else suffers."

Were Professor Fingarette to experiment with a strictly secular approach to criminal law that considers our moral values as represented in law by its proscription of certain acts rather than by moral judgment of individuals, he would find himself examining courtroom business as the humane prevention of crime under the rule of law. Determining criminal responsibility would then appear to be a selection process in which the court decides whether or not deterrence, rehabilitation, and incarceration, its means of preventing crime, are to be applied in the case of the accused.

This selection process requires an explicit rationale as to why and how various violators of the law are to be handled so that crime can be prevented. Such a rationale would provide naturalistic, deterministic concepts appropriate to this mundane problem in social engineering. The rationale will get exactly the same job done as does the moral judgment of individuals, but without the metaphysical confusion and inefficiency that have haunted criminal responsibility over so many generations. I have attempted to provide this kind of rationale in two papers (1, 2).

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Psychobiology of Convulsive Therapy, *edited by Max Fink, Seymour Kety, James McGaugh, and Thomas A. Williams. Washington, D.C., V.H. Winston & Sons (New York, N.Y., Halsted Press, John Wiley & Sons, distributor), 1974, 294 pp., $11.95.*

Careful reading of this book is thought provoking and therefore time-consuming. It is an excellent compilation of research data on electroconvulsive therapy. The editors even cover their sociological reasons for preferring the term "electroconvulsive therapy."

The conscientious reader of this volume can easily pick up from 10 to 50 quotations, truths, or aphorisms about ECT that are supported by appropriate research and clarified by an honest appraisal of their limitations. The density of the data input, however, is such that I was reminded of the first two Kinsey reports. This is not a textbook to be read and understood at one sitting and then laid to rest but, rather, an excellent book to skim, retain, and have on the shelf for intermittent study and reference.

The editors are major investigators in the area of ECT. Their essays on basic research in people and animals with appropriate, accurate, and limited generalizations are combined with reports from about 25 other investigators.

The first 12 articles all have excellent and useful brief summaries. The subjects covered include "Induced Seizures and Human Behavior," "Unilateral Electroconvulsive Therapy," "Is EEG Slowing Related to the Therapeutic Effect of Convulsive Therapy?" "Electroconvulsive Therapy and Sleep," "EEG and Neurophysiological Studies of Convulsive Therapies," "Inhalant Convulsive Therapy," "Multiple ECT: What Have We Learned?" "Electroconvulsive Shock: Effects on Learning and Memory in Animals," "Retrograde Amnesia and Brain Seizures in Rodents: Electrophysiological and Neuroanatomical Analyses," "Effects of Flurothyl (Indoklon) Upon Memory in the Chick," "Effects of Electroconvulsive Shock on Norepinephrine Turnover and Metabolism: Basic and Clinical Studies," and "Effect of Repeated ECS on Brain Weight and Brain Enzymes."

The following seven essays cover such subjects as "The Effect of Electroshock on Brain RNA and Protein Synthesis and Its Possible Relationship to Behavioral Effects," "Memory and ECT," "Systemic Biochemical Effects of ECT," "Effect of Electroshock on Indoleamine Metabolism and Aggressive Behavior," "Effects of Repeated Electroconvulsive Shock on Brain Catecholamines," "Effects of Electroconvulsive Shock on Cerebral Protein Synthesis," and "Brain Acetylcholine and Seizures." These articles lack useful summaries.

Readers looking for an index work on current research areas and names of active investigators in the field of convulsive therapies will find this a comprehensive, excellent, and useful volume. Readers seeking aid in modifying indications for ECT or in determining relative evaluations of its effectiveness in the treatment of various syndromes will be disappointed. However, if one is looking for scientific data to justify modification of ECT techniques to achieve greater effectiveness in the treatment of depression with decrease in memory loss, he may be satisfied.

The reader should not expect this book to provide a major compilation of data justifying the use of ECT or to provide fac-

ile answers to the recent attacks on this mode of therapy. The articles were written before the attack, by clinicians and researchers who generally accept the efficacy of the convulsive therapies because of their own experience.

I would suggest that many readers might prefer the "detective story" method of reading this book: after reading the first two introductory chapters and comments, progress to the three final summary chapters. Then, if still interested in details, go back to the intermediate, data-filled chapters.

The reader should not expect to find the answer to the problem of how or why ECT is effective. Each of the investigators is able to establish the presence or absence of specific changes in other systems (e.g., EEG, memory, indoleamine metabolism, brain catecholamines, and norepinephrine metabolism) during ECT; in some cases the investigators are able to establish a degree of correlation with behavior change. However, none of them makes any claim that the related system changes have a direct and causal relationship with clinical improvement after ECT.

All of the authors clearly caution against the dangers of a direct application of animal research findings to human behavior. This attitude is perhaps best summarized by the following statement of Dornbush and Williams:

> These findings are difficult to relate to outcome in man and the relevance of these studies to the mechanism of action of ECT is difficult to judge, since few studies provide similar dosage and duration of stimulations, seizures frequency, and electrode locations to those assessed in man. Additionally, effects on language ability, so critical in studies of memory tasks in man, are essentially untestable in animals. (p. 202)

Valzelli and Garattini point out the following divergent results from common stimulations even in rats and mice:

> From the behavioral point of view, electroshock is unable to modify the aggressive behavior produced in mice by isolation, but is very effective in blocking the muricidal reaction produced in rats by isolation. (p. 227)

A number of valuable essays that explore ECT in relation to memory processes and behavioral changes are presented in this book. It is a good summary of the current status of the field, and it makes it clear that more can and must be learned to explain the whys of the clinical applications of convulsive therapies.

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The Schreber Case: Psychoanalytic Profile of a Paranoid Personality, *by William G. Niederland, M.D. New York, N.Y., Quadrangle/New York Times Book Co., 1974, 166 pp., $8.95.*

The outlines of the case history of Daniel Paul Schreber are well known to the majority of the readers of this journal. Freud's famous study, "Psycho-analytic Notes Upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)" (1), has been the focus of thoughtful arguments concerning the psychodynamics of paranoid thinking since its publication in 1911.

Dr. Niederland has written a "handbook" of the Schreber case in a way possible for him alone. His long, meticulous, and exhaustive search of all the written material about Schreber and his contacts with relatives and friends of the family make this volume a unique contribution. That Dr. Niederland received his medical training in Germany and is intimately acquainted with German culture, history, and, most of all, nuances of language allows him a special perspective that is clear in his written work.

The author's major theme, simply stated, is that the "kernel of truth" in delusions and hallucinations can often be discovered when the psychoanalyst is able and willing to view the deluded person's life history in depth. This means that the person's verbal productions, his behavior in general, and his personal and family histories must be taken into account with the appropriate emphases. And that is not all. That behavior and those histories must be viewed in a way relevant to the state of the society in which the person lives.

All of this makes the study of psychobiography very difficult indeed. Furthermore, the psychoanalyst stretches his science to a limit when he seeks to understand the dynamic meaning of the behavior of a person who is communicating only in writing, and not even writing to a psychoanalyst in order to obtain understanding. When the writer has been dead for many years, the problems are even greater.

Careful workers in the field of psychobiography are aware of how risky it is to arrive at solid hypotheses, let alone valid conclusions. However certain the analyst may think he can be, he must always remind himself and his audience that the person in question is not available for comment. The writer was not trying to be understood by the analyst, and he was not committed to the effort of free association as is a patient in psychoanalysis. That, after all, is the situation in which the analyst's formulations have the greatest validity.

It seems to me that Dr. Niederland is very aware of these limitations and functions well within them without completely stifling his creative imagination.

Dr. Niederland gives historical weight to Freud's original formulations and speculations. His researches have established beyond a doubt the enormous importance Dr. Schreber held for his son Daniel. The relationship between the son's many delusions about his body and the father's fanatical preoccupation with physical fitness, growth, and development is quite clear. The son's strong identifications with his father are underlined, as are the son's unconscious castration anxieties and hostility toward the father. Dr. Niederland draws striking parallels between the times of illness of father and son.

From a metapsychological point of view, the author emphasizes the ego aspect of the construction of a delusion. That is, specific infantile traumata are cast in a particular form not by instinctual pressures alone but by the stage of development of the ego and its perceptual capacities vis-à-vis these external events. Dr. Niederland has been able to document psychoanalytic constructions with historical fact. It is rare for the clinical psychoanalyst to have such an opportunity.

In the third section of the book, composed of excerpts of writings by other authors, Arthur Carr recounts some of the challenges to Freud's early formulation of the nature of projection. Many authors refuting the relationship between paranoia and homosexuality do not take into account that what is postulated in the formulation is that projection occurs as a defense against *unconscious* homosexual impulses, not conscious homosexual inclinations.

I found the single distracting element of this book to be the fact that it remains a collection of papers. Although the first two sections are organized around Dr. Niederland's own research, the papers are excerpted. This makes for disruptive reading. It also results in a considerable amount of repetition of facts and historical material in each paper. In the third section there are a number of important articles by other authors. A

lengthy paper by Maurits Katan and the two rather well-known papers by Robert White on Schreber's mother and his life viewed from the standpoint of psychosocial concepts are particularly deserving of a response by Dr. Niederland.

I wish Dr. Niederland had quoted these papers in a review of literature and then discussed them in the context of his own research. If he had then brought his own work together in the form of a new book, the presentation would have been more cohesive.

In summary, this is a remarkable piece of work that only Dr. Niederland has the knowledge to write. He is to be commended for getting this material together into one volume. It is a book that should be read by the serious student of psychoanalysis. The author writes well and with enthusiasm. His papers are a pleasure to read and should serve as a model for psychobiographers who study writers, their works, and their lives.

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Clonotherapy: A Manual for Convulsive Therapies, *by Lionel H. Blackman, M.D. Lake Worth, Fla., Lionel H. Blackman, 1974, 104 pp., no price listed (paper).*

The literature on convulsive therapy is very limited because interest in somatic treatments in psychiatry centers around pharmacotherapy. Therefore, the publication of a manual on this subject should be welcome. The author uses the term "clonotherapy," introduced by the English psychiatrist Louis Rose, in an attempt to avoid the unpleasant connotations of the terms "shock" and "convulsive."

One objection to the term "clonotherapy" is that the tonic rather than the clonic phase is the essential evidence of a complete generalized seizure that is necessary for a therapeutic response. It is doubtful that any attempt to make the name of the treatment more palatable to the patient will be successful or even legally acceptable. It is interesting that the consent form used by Blackman requests authorization for "clonotherapy (electro-convulsive and/or Indoklon)."

Treatment with both electrically induced convulsion and inhalation of the fluorinated ether Indoklon is described. Indoklon is a useful alternative to ECT in refractory cases. The author's experience has been that young schizophrenic patients respond better to Indoklon. Although no comparative study exists, many psychiatrists who have used Indoklon tend to agree with this idea. It is therefore regrettable that the company that manufactured Indoklon discontinued its production.

This manual is essentially based on the practical application of "clonotherapy," documenting it with a large number of pictures and case reports. In a theoretical chapter Blackman claims that incomplete convulsions (subconvulsive petit mal, sleep-type responses) require a greater number of treatments. This is contrary to the view of most psychiatrists that subconvulsive treatment is actually ineffective. It is an open question as to how unilateral ECT with the usually bilateral convulsive response compares with the efficacy of bilateral ECT. If Blackman discusses the effects of unilateral ECT with "hemiconvulsion," it must be said that there is no way to produce such unilateral response at will.

Another chapter is dedicated to "multiple monitored electroconvulsive treatment." This treatment requires the continuous drip application of succinylcholine by an anesthesiologist. However, the author does not seem to use an anesthesiologist in practice.

The book is written for the practitioner of ECT. Although it contains many useful suggestions, one finds some statements that cannot be easily accepted, e.g., such remarks on indications as that optimal results are seen in "acute depressions such as reactive depressions." While it is not justified to eliminate ECT in reactive depressions, as has been done in the model criteria issued by APA (1), the response of reactive depressions to ECT is certainly inferior to the response of endogenous depressions. Blackman's contention that agitation as such is an indication for ECT, including agitation found in severe forms of anxiety neuroses, where the diagnosis is agitated depression, is even more questionable.

Blackman provides 36 case reports showing that strict adherence to classification and indications is not indispensable for satisfactory therapeutic results with ECT.

One cannot ignore some mistakes in spelling such as the repeated use of the word "curari" for "curare" and the name Cellitti for Cerletti.

It is generally regretted that the student in psychiatry, both undergraduate and postgraduate, receives extensive training in psychological methods of treatment but little or no training in somatic modalities, including the vast field of pharmacotherapy, which is so important in psychiatric practice and research. Considering the particular lack of any teaching of convulsive therapy, a manual like this is welcome, even if it has shortcomings. It should be helpful for psychiatrists applying a treatment that continues to be most successful with some of the sickest psychiatric patients.

REFERENCE

1. American Psychiatric Association Ad Hoc Committee on Professional Standards Review Organizations: Model Criteria Sets. Washington, DC, APA, 1974

LOTHAR B. KALINOWSKY, M.D.
New York, N.Y.

Season of Birth in Schizophrenia and Other Mental Disorders, *by Per Dalén. Göteborg, Sweden, Psychiatric Research Centre, St. Jörgen's Hospital, University of Göteborg, 1974, 123 pp., no price listed (paper).*

The author addresses himself particularly to variation in the season of birth of schizophrenic patients. As an introduction, he provides a comprehensive bibliography of studies of season of birth that should be of use to any investigator starting out in the field. The analysis is based on all discharges from Swedish mental hospitals from 1962 to 1968, more than 400,000 in all. Also included in the analysis, in order to ensure the inclusion of patients who were in the hospital throughout the period of study and not discharged, are patients obtained from the annual census of mental patients.

Variation by season of birth for any condition is highly suggestive of the operation of an environmental determinant. It is difficult to hypothesize any plausible genetic factor that could produce such an effect. On the other hand, many plausible environmental factors, including infection, temperature, weather, and nutrition, vary by season. In this regard Dalén provides a set of data that cannot be ignored.

He takes account of and is able to dismiss two important

sources of confounding. The first is variation in fertility by social class, which was more likely to suppress than to confound the result. The second is that variation in mortality (especially infant mortality) by season may produce among survivors a spurious appearance of variation by season of birth. An analysis of infant mortality for the study cohorts showed that its effects could not account for the demonstrated finding that there is an excess of births in the months of January through April among schizophrenic patients. The removal of this source of confounding is, I believe, unique to the study.

This finding is consistent with those of several previous studies in northern and western Europe. Dalén also provides a unique test of the generality of the phenomenon by seeking out a sample of mental hospital patients in South Africa, in the southern hemisphere. Again he found a similar season of birth for birth effect, although it does not precisely mirror the effect in the northern hemisphere and is somewhat more irregular, possibly because of the smaller number of subjects involved.

Although the size of the sample and the completeness of the data on the general population from which expected distributions were obtained are great strengths of this study, the data source also has a major weakness. The weakness lies in the fact that the investigator was unable to segregate first admissions from others. He is therefore dealing with data that resemble a measure of prevalence much more than incidence of the diseases studied. Prevalence data, of course, are not efficient in the search for etiological factors.

In this study, however, the bias introduced by this measurement is more likely to suppress the result than to exaggerate it. This becomes clear in the analysis of duration of stay in the hospital by season of birth: schizophrenia relates more closely with season of birth among admissions of short duration than among those of longer duration. Dalén interprets these results as showing that season of birth relates to the prognosis of schizophrenia. In my view, a sounder interpretation would be that season of birth is likely to be related to the incidence of schizophrenia but not to those circumstances which lead to chronicity and chronic disability with schizophrenia.

The presentation and discussion of these data are somewhat disappointing. Explication done in shorthand tends to obscure rather than illuminate. The description of the actual sample used is somewhat confusing: previously Dalén used a sample of discharges from 1962 to 1964 and published data on these, and the distinction between this first sample and the complete second sample is not always clear. The labeling of tables is inadequate and far from self-contained. Despite these problems, however, this analysis contributes a confirmatory result to the literature that must be taken into account in framing hypotheses about environmental factors in schizophrenia.

MERVYN SUSSER, M.B., B.CH.
New York, N.Y.

Dementia in the Presenium, *by Andrew Edmund Slaby, M.D., M.P.H., and Richard Jed Wyatt, M.D. Springfield, Ill., Charles C Thomas, 1974, 214 pp., no price listed.*

This is a short, well-organized, and competent review of the dementias in the presenium, clinical entities with which many contemporary psychiatrists and mental health professionals have little experience. The authors point out the importance of the early recognition of these syndromes so that treatable cases are, in fact, treated and so that the patient does not undergo long, wasteful periods of useless psychotherapy with inappropriate expectations.

The authors effectively define the boundaries of the syndrome, discuss how the presenile dementias might be classified, and, in a chapter titled "General Conditions," review their history and diagnosis. They review findings on physical and mental status examinations as well as blood, urine, cerebrospinal fluid, and X-ray examinations. Electroencephalography, cerebral angiography, isotope encephalography, neuropsychological studies, cerebral biopsy, and studies of cerebral vascular blood flow are also discussed. Following a tightly written, 40-page general introduction, the diseases are considered one by one, and their clinical course, diagnosis, and pathology are discussed.

Although it provides a very valuable reference, this book suffers from the absence of clinical vignettes. As a result, some of the subtleties of differential diagnosis and the use of psychological tests, for example, are not adequately brought into focus. Had the authors presented the details of clinical material, the reader would have a more vivid appreciation of the presentation and clinical course of patients with presenile dementias.

The book thus provides an orientation to these illnesses and alerts the practitioner to the likelihood of coming across such patients. The book would be of particular help in deciding how to proceed with a differential diagnosis when dementia is suspected in a patient. Without case history material, however, the subject does not quite come to life.

JACK DURELL, M.D.
Washington, D.C.

Sexual Identity Conflict in Children and Adults, *by Richard Green, M.D. New York, N.Y., Basic Books, 1974, 319 pp., $15.00.*

Throughout history, people who have lived their entire lives as members of the opposite sex have occasionally been described. However, this rare but striking phenomenon, transsexualism, has been studied intensively only in this century. A major figure in the science of normal and aberrant gender identity is Dr. Richard Green, who, with Dr. John Money, edited *Transsexualism and Sex Reassignment* (1). In that book the editors brought together a good deal of what was known about the surgical procedures, endocrinology, treatment, and etiology of the adult disorder.

In *Sexual Identity Conflict*, Dr. Green focuses on innovative clinical studies of young boys and girls who wish to change sex. We now know, and the data supporting this knowledge are set forth in this book, that at least some of these children grow up to become adult transsexuals.

Dr. Green's method of presenting clinical material is intriguing: transcripts of recorded interviews with the children in therapy sessions are presented along with the clinician's behavioral overview and the parents' descriptions of the same children. Dr. Green then comments on his interpretation of the patients' statements. "Hearing" young boys describe their feelings, through the medium of the transcripts, will be an eye-opener for those not familiar with the clinical presentation of gender identity disorders. In effect, we sit beside Dr. Green as he does his work; we are then able to make our own observations of the data and draw our own inferences.

The book includes some important chapters on the psychological testing of feminine boys, including extensive discussions of new instruments designed by Dr. Green and his coworkers for these investigations.

One fascinating chapter concerned a study of genetically identical twin boys, one of whom was masculine and one of

whom was feminine. Dr. Green elegantly describes the multiplicity of potentially etiologic factors and their variants in the lives of these boys. We are left with the same puzzle about the etiology of the condition but with deepened insight into the problem. This chapter alone made the book worth reading for me.

There are excellent reference chapters on historical and cross-cultural reports of individuals with gender disorders as well as chapters on psychological theories and biological studies of individuals manifesting gender identity problems. Dr. Green also reports some research on the role of the temporal lobe, hormonal factors during gestation, and studies of individuals with sex chromosome anomalies and aberrant sex behavior.

The book also contains chapters on masculine girls, on women who became men, and on the girlfriends and wives of these individuals. Dr. Green again makes use of the technique of recorded transcripts to bring home powerfully to the reader the impact that interviewing such persons firsthand makes on the clinician.

Finally, there is a chapter on problems for further research. Here the multifaceted problems and the lines of present research are described. If the book has any weakness it is that Dr. Green refuses to point toward a direction—to indicate the investigatory strategy that he believes is most likely to yield success in uncovering presently unknown factors. Rather, he makes us think deeply about the problem of the nature and development of gender identity, not only in regard to the rare aberrant individuals but, by implication, in regard to normal individuals as well. The book is mind expanding in the best sense of the word, and I recommend it to all who struggle for a deeper understanding of the nature of human sexuality and sexual identification.

REFERENCE

1. Green R, Money J (eds): Transsexualism and Sex Reassignment. Baltimore, Johns Hopkins University Press, 1969

LAWRENCE E. NEWMAN, M.D.
Los Angeles, Calif.

Psychiatric Disorders in Adolescents, *by Richard W. Hudgens, M.D. Baltimore, Md., Williams & Wilkins Co., 1974, 228 pp., $15.50.*

This book contains useful information, but its title is misleading. The book is based on a study of a very narrow adolescent population clearly identified as such in the introduction, which states,

> [The study] does not deal at length with some of the disorders commonly found among psychiatrically ill adolescents, such as chronic brain syndromes, mental deficiency, or severe and repetitive criminal behavior. . . . [It] does not discuss in depth those disorders for which teenagers are seldom admitted to a psychiatric hospital, for example, hysteria, anxiety neurosis, obsessive-compulsive neurosis, phobias, sexual deviation, and relatively uncomplicated learning disorders.

Thus the title implies a breadth and scope not attempted within the pages of the book.

The author presents a detailed study of 220 adolescents, 110 of whom were psychiatric inpatients and 110 of whom were hospitalized controls. He identifies three purposes for this study of adolescents who were hospitalized at least once before they were 20 years old. One purpose was to "provide a more complete systematic classification and description of psychiatric disorders among teenagers." It would seem difficult to fulfill this purpose, because a significant cross-section of psychiatric teenage patients was not studied.

A second purpose was to gather information to provide a basis for comprehensive follow-up study of psychiatrically ill adolescents into adulthood. The third was to provide a "prospective study with systematic attention to the chronology of positive and negative psychiatric, sociologic, and medical features."

It is always frustrating for one to review a book that has useful and interesting information and yet find that certain basic features may mislead the reader. Given the facts that the book concerns a study of inpatient psychiatric adolescents only and that the possibility of prospective studies and a comprehensive follow-up would be only for a narrow population, the book then progresses toward its stated purposes.

A discussion of diagnostic problems and a brief review of treatment considerations for the adolescent are presented compactly. However, although it is noted in chapter 9 that "most adolescents who need psychiatric treatment will never be inpatients," the treatment section then deals specifically with problems commonly encountered in an inpatient hospital setting.

With these factors in mind, this book offers useful information on an adolescent inpatient population, with good demographic and statistical information provided on both the psychiatric group and the control group.

RICHARD E. DAVIS, M.D.
Norfolk, Va.

Masked Depression, *edited by Stanley Lesse, M.D., Med.Sc.D. New York, N.Y., Jason Aronson, 1975, 367 pp., $12.50.*

The World Health Organization has concluded that depression is a major public health problem throughout the world. This was announced at an international symposium on depression and its treatment held in Switzerland in January 1974. Dr. N. Sartorius, senior medical officer of WHO's Office of Mental Health, told the assembled doctors that there are almost 100 million people in the world who suffer from some form of depression and who could benefit from help.

This impressive statistic does not include the equally if not more numerous people with masked depressions (also referred to as depressive equivalents or affective equivalents). Despite the high incidence of masked depression, there is a paucity of literature on the subject. However, this woeful lack of authoritative information on masked depression, its many clinical manifestations, and its treatment is more than adequately compensated for by the 18 expert contributors to this well-edited, very readable, comprehensive book.

Various psychosomatic disorders or hypochondriacal complaints in different organ systems are the best known clinical manifestations of masked depression. However, Stanley Lesse stresses,

> Depressions may also be disguised by various types of "acting out" or behavioral disturbances. These behavioral masks may take the form of antisocial acts, impulsive sexual behavior, compulsive gambling, temper outbursts, destructiveness, sadistic or masochistic acts, compulsive work or behavior patterns, accident-proneness, histrionic

dramatizations, and more. Less commonly, referential or delusional patterns may be discerned as masking processes. The depressive masking may also take the form of acute or chronic alcoholism or bulimia. Finally, it may manifest itself in the form of narcotic addiction, barbiturate habituation, the use of stimulant drugs, and the use of psychedelic agents such as lysergic acid or mescal derivatives.

A masked depression may occur at any age. This book therefore contains chapters on this disorder in children, adolescents, adults, and the elderly. There are also chapters on cultural variations of depression, genetic factors associated with affective equivalents, masked depression and suicide, and the treatment of masked depression with psychotherapy alone and in combination with antidepressant drugs.

Despite its prevalence, masked depression is seldom recognized quickly, if at all, by many physicians and psychiatrists, partly because of a lack of awareness of this disorder and its myriad manifestations. There is a wealth of invaluable information in this book that will enable doctors to recognize and treat masked depression. Clinicians and teachers would be enriched by careful study of this book's contents. I therefore unreservedly recommend it.

FRANK J. AYD, JR., M.D.
Baltimore, Md.

Serve the People: Observations on Medicine in the People's Republic of China, *by Victor W. Sidel and Ruth Sidel. Boston, Mass., Beacon Press, 1974, 307 pp., $4.45 (paper).*

Here is a book by individuals with a deep respect for the Chinese people and their heroic attempts to provide optimum health care for all members of China's society. Through their personal observations and a careful survey of the available statistical data, Victor W. Sidel, a physician specializing in community medicine, and his wife, Ruth Sidel, a psychiatric social worker, have put together a most informative volume describing health care delivery in the People's Republic of China.

Tracing the evolution of the current health care organization within the context of changes in the political and social structure of that vast land, the authors attempt to interpret the natural growth of China's efficient health care system. The authors carefully delineate public health trends and methods of medical education. They describe in detail the changed role of the physician, who seems now to be perceived as a medical "worker" like the rest of the labor force.

Using the Chinese slogan "Serve the People" as its title, the book explores the highly utilitarian and practical character of modern Chinese medical practice. It explains how this has been achieved by a blending of Western medicine with traditional Chinese medicine as well as by the harnessing of all the natural resources opportunely present in the people and in the land. The authors describe how new physicians, supported by their double medical heritage, are brought closer to the people and the land and how this leads to the delivery of first-rate medical attention to people in the cities as well as in the countryside. The role of the political leadership in inculcating the idea that mental work and manual work are equally productive and deserving of respect is also described.

The authors' commitment to Sinitic studies opened the hearts of their Chinese hosts, who in turn responded trustingly with a considerable amount of information about medical and social practices. The Sidels' attempt at comparing the system in China with health care delivery systems in other countries—particularly Israel and the Soviet Union—provides interesting insights into the changing role of physicians, the training of physician's assistants, and the concept of social work.

For the psychiatrist this book lacks adequate description of the social work services in psychiatric settings. It would be interesting to know how these services are absorbed by the other components of the system in the absence of professional psychiatric social workers. There is also scant reference to the therapeutic applications of group phenomena, which are pervasive forces in everyday life.

A large body of facts is assembled in this book, some as a catalog of figures provided by the Chinese medical authorities. Considering the relatively recent reopening of the gates between China and the Western world, it is some wonder that the authors have collected so much.

The book covers a great many facets of Chinese life. It would be stimulating for medical professionals, teachers, students, and health care administrators. Western physicians, who practice in a free enterprise system, would be inspired by the relationship between provider and consumer in matters of health care. The public, who justifiably complain of the shortage of doctors, their unavailability at short notice, and the high cost of medical care, might also ask how some of the Chinese innovations might be transferred to their own communities.

DAVID N. RATNAVALE, M.D.
Norfolk, Va.

A Child's Parent Dies: Studies in Childhood Bereavement, *by Erna Furman. New Haven, Conn., Yale University Press, 1974, 308 pp., $15.00.*

The jacket of this book states,

> This study of twenty-three children who suffered the death of a parent during childhood seeks to understand the psychological impact of bereavement on the young and to offer concrete suggestions for helping children to cope with their loss.

This study does very well what it seeks to do, in terms of both understanding and advice. The thought of a grieving child is so painful that some therapists might rush to be massively supportive. The author makes the point repeatedly that the child cannot be spared the pain and distress of mourning. The care and support from the surviving parent help the child to bear it. Furman urges that we help the child "to understand the concrete realities of death and to distinguish between what we can objectively perceive . . . [and] what we believe about death privately or according to our religion."

The use of developmental levels and the combining of emotional and cognitive experiences are comprehensive and make the book's content logical, memorable, and usable for therapists of many persuasions. Object loss is given a good deal of recognition, and distinctions among the kinds of partial object loss are made. The author keeps in perspective the ways in which bereavement is different for children than for adults.

Extensive case histories provide "clinical" data to illustrate the author's theoretical considerations. Many readers will find these excessively long. A few case reports, although detailed, are not representative of research. There are, however, many short clinical vignettes woven into the theoretical discussions. Most readers will appreciate these for their pointed illustration of principles.

The second chapter highlights what is to follow in more detail. It also offers some very useful advice on helping bereaved children. If one has time to read only one chapter, he would do well to choose this one. More likely, he will be persuaded to read on.

Mourning is defined as "the mental work following the loss of a love object through death." The questions of whether it has to be the loss of a love object or, for example, the loss of body functions or inanimate objects and whether the loss must occur through death or, for example, through permanent separation are thoughtfully explored. The process of mourning is discussed in relation to withdrawal of attachments (decathexis), remembering and longing (hypercathexis), and identification. Coping with the fear of death, the significance of the form of death, and stressful events preceding death are also given attention.

After the death of a loved one, the bereaved faces three tasks: "to cope with the immediate impact of the circumstances, to mourn, and to resume and continue his emotional life in harmony with his level of maturity." If the bereaved is a child, the difficulties of the tasks may be particularly great. Completion of tasks is not time limited, and the child may experience difficulties in resolving any one of them, either during the period immediately following the death or in subsequent years, as new developmental milestones require age-appropriate methods of coping. The author discusses a variety of these difficulties and illustrates them with case material.

In a chapter titled "Observations on Depression and Apathy," the author attempts to gain a better metapsychological understanding of the phenomena of depression and apathy as well as to clarify their clinical pictures. The first task proves very difficult, but the second is more successful. The last portion of the text contains an extensive and quite readable review of the literature on studies of mourning and a discussion of their relationship to the work described in *A Child's Parent Dies.* While it is more readable than many reviews of the literature, it is perhaps overly long.

This is not a book that would be helpful to any but the most sophisticated parents or lay people. It is a very good book for clinicians who are attempting to understand bereavement in childhood and to deal therapeutically with it.

JOSEPH M. GREEN, M.D.
Tucson, Ariz.

Clinical Prediction in Psychotherapy, *by Leonard Horwitz. New York, N.Y., Jason Aronson, 1974, 365 pp., $15.00.*

Nowadays "psychotherapy" encompasses at least 30 avowedly discrete methods. Twenty years ago a student could feel competent if he mastered the distinction between psychoanalysis and psychotherapy, one being pure gold, the other an alloy and, by metaphoric implication, baser stuff. This book reports in some detail the differences in two technical approaches practiced by a group of fully trained psychoanalysts over a 15-year span. One of the therapeutic approaches is called "psychoanalysis" and the other "psychoanalytically oriented supportive therapy."

In our clinic, social workers, psychologists, residents, and medical students sit side by side week after week at intake conferences making guesses about who will do best with which therapist and which therapy. Marriage therapy, drug therapy, behavioral modification, progressive relaxation, long-term therapy, and crisis intervention are tricks every psychiatric resident tries to include in his bag. Psychoanalysis and psychoanalytic psychotherapy still occupy a special niche somewhat outside of the general ken.

Yet all of us are vitally concerned with clinical prediction. We observe people who seem to get better after a few interviews; we observe others who return year after year for this therapy and that. We know the embarrassment of stalemates and the shock of unexpected suicide. Therefore, a book with this title promises much. The question is whether the conclusions of the psychotherapy research project begun in 1954 at the Menninger Clinic and reported, in part, in this text have general applicability and more than subspecialist interest. In my opinion, this book does have general value, but to read it requires some forbearance for psychoanalytic vocabulary and clinical research.

The opening chapters are taken up with an overview by Wallerstein and a discussion of methodology. The aim of the research was to make specific predictions about what would happen during psychoanalytic treatment and to later sum up the outcome of all prognostications. In order to accomplish this goal, a research team studied the process notes of a group of psychoanalysts who were treating a group of 42 nonpsychotic patients.

The durations of treatment were very long by typical outpatient clinic standards. The shortest case entailed 46 interviews within a year; the longest persisted for 10 years. The usual duration seems to have been about 4 years. Perhaps this major difference between psychoanalyst-dominated treatment centers and community mental health clinics reflects an underlying concept: the psychoanalyst may think of himself as a perfect parent while the community clinic imagines itself to be a general store providing supplies to a deprived neighborhood.

In any event, the gross results of the two differing approaches are difficult to compare. What psychiatric residents often wonder is whether this or that patient might "really" improve if he or she were to continue indefinitely with a senior psychoanalyst in depth therapy. The conclusion Horwitz reaches is a qualified yes. One of the qualifications is that structure does not change or, more precisely, that the concept of structural change is useless. Instead, he opines that diverse forces such as a wish to please and introjection of the therapist's traits may combine with a rewarding environment to produce relatively stable adaptive changes. Another qualification would be that "narcissistic" patients do not improve; this conclusion has led the Menningers to institute a policy of elaborate psychological testing before starting psychoanalytic treatment.

One line of thought in psychoanalysis has been the refinement of accuracy of interpretations. An unusual section of this book is an appendix that contains some 500 predictive statements as well as a hierarchically structured outline of the interrelationship of these psychoanalytic propositions. Psychoanalysts will be interested in comparing this section with the theoretical expositions of David Rapaport and Edward Glover. The general reader, who may not appreciate how analysts have struggled to distinguish "exact" from "inexact" interpretation, may find this section tedious. The close reader will enjoy the postdictive propositions (about 150 out of the 500) that indicate subtle shifts in explanations to account for unpredicted changes in the psychoanalytic encounter.

But what about general relevance? If one contrasts the detailed formulations of this psychoanalytic study team with the determinedly vague approximations of a typical intake conference, the gap seems wide indeed. Yet Horwitz' theory of psychotherapeutic influence bridges the gap; his idea is that patients are unpleasant folks who alienate others and who would not need a psychotherapist if they were able to make friends. Thus, whether a succession of "bought" friends is supplied by a health clinic or one analyst continues to treat the

patient for 10 years, the potential is the same.

Horwitz concludes that the person who is helped by psychotherapy comes with a disposition to "experience a good object" (fall in love with an upright therapist?), attracts special attention, and, when all goes well, begins to feel enhanced and to act more like the therapist. If feeling enhanced and acting this new way is rewarded by other people, then relatively permanent changes occur. It would be difficult to quibble with this description of what happens. It is difficult, however, to anticipate who will work well with whom or who will take inspiration and hope from whom. What therapists, like golf pros, try to find is a repeating swing that works in unexpected as well as average expectable environments. What patients hope for is someone who will understand and give aid—a friend in need is a friend indeed.

The implications of this research will comfort neither psychoanalysts nor community clinic administrators. As I understood it, the research concludes that if two people commit themselves to one another for a few years, both may profit. Psychoanalysts will mourn the loss of technical trappings; community mental health will wonder about short-term help and the idea that therapists are interchangeable soldiers on the lines against the enemy (the sick). Similarly, researchers committed to microanalysis must dismiss the conclusions as a gloss, as missing the process. But the clinician, who is unlikely to read this particular volume because of stylistic mannerisms and peculiar typeface variations, will find support here.

Finally, there is no discussion of the redemptive aspect of psychotherapy. It is important to have a friend, but is a friend enough? Many of us who are therapists have hoped to provide more. We have hoped to provide salvation through science; if we have been but bought friends, no matter. We have sharpened the focus on the issue of commitment.

ROBERT VOSBURG, M.D.
Hanover, N.H.

The EEG in Acute Cerebral Anoxia: Assessment of Cerebral Function and Prognosis in Patients Resuscitated After Cardiorespiratory Arrest, *by Pamela F. Prior. Amsterdam, The Netherlands, Excerpta Medica, 1973, 314 pp., $36.95.*

This is a proper book of a type no longer in fashion. It replaces what could have been a multiplicity of short reports by different authors in a variety of journals or isolated chapters in symposium volumes. It allows various subsections of studies on its chosen topic to be integrated and presented in depth. It benefits from the advantages of one author with a uniform and clear style, which results in a comprehensive report on a subject with genuine personal implications. The author's gracious acknowledgments clearly indicate the degree to which this book is a result of careful collaborative effort. The subtitle, *Assessment of Cerebral Function and Prognosis in Patients Resuscitated After Cardiorespiratory Arrest*, indicates a concern with prediction of outcome.

The EEG department of London Hospital had 127 patients referred for examination for assessment of damage following cardiac or respiratory arrest over a period of five years. Adequate data on 115 of these patients constitutes the basis for this report; 93 of these patients were selected for more detailed analysis.

One of the book's appendices lists 49 EEG variables with up to 9 points for each that were subjected to both linear and nonlinear function analysis by computer to yield a set of discriminators to predict survival versus brain damage in these patients. A 32-variable classifier was then further reduced to a 13-variable system, each item having a usefulness factor given as a percentage. Whereas a simple 5-point visual-rating EEG score yielded an 80 percent accurate prediction of outcome, the use of more (up to 13) variables resulted in accurate and virtually complete separation of the two groups.

The clinical and EEG items are described in sufficient detail to allow others to adopt the technique. The translation of the EEG features into words is greatly facilitated by the inclusion of a large number of EEG figures. These are meticulously documented with respect to montage and all recording measurements. There is somewhat more emphasis on preservation of a wide range of frequency response, with the honest inclusion of artifact, than on gain or sensitivity. Other features of particular interest to the EEG professional and technologist include the type of reference recording used, the frequent absence of other indicated physiologic monitors (the tracings are remarkably free of EKG contamination), and the use of the cerebral function monitor.

The horizontal page layout is well adapted to the display of EEG figures. Much can be learned from these, although the arrangement of topics creates some difficulties in following the sequence of events for some patients. Different aspects of the data may be entered under a variety of headings, so that one has to search out the sequence of EEG changes on widely separated pages. However, replication of the data in text and legend is helpful, and there is a more compact presentation of case material in an appendix that deals with 41 of the patients.

This is a book for serious reading, not for browsing or quick reference. It includes a very extensive survey of the pertinent world literature. In view of the author's manifest technical competence in EEG, this review of the literature is paradoxically noncritical. Prior has made a genuine contribution by showing that high-quality EEGs, intelligently used, can be an effective predictor of outcome following cardiorespiratory arrest. The pathological findings indicate that the basic event is that of the degree of perfusion failure, with related cerebral anoxia.

There is good value in this book. No EEG laboratory involved in the bedside study of acutely ill patients, which is where the action is, can afford to be without ready access to these data.

CHARLES E. HENRY, PH.D.
Cleveland, Ohio

A Strategy for Handling Executive Stress, *by Ari Kiev, M.D. Chicago, Ill., Nelson-Hall, 1974, 169 pp., $7.95.*

During the past three to four years, several books have been published on the subject of executive stress (1–3). Dr. Kiev's short book attempts to provide a strategy for handling this stress, making it somewhat different from its predecessors. Kiev states,

> [I am not] concerned so much with pathological patterns of behavior [which manifest themselves in psychological or physical symptoms and show up in all levels of the organization] but with subtle patterns of self-defeating behavior which show up in interpersonal and intrapsychic conflict; and in patterns of nonperformance that are reinforced by the bureaucratic nature of a large corporation. (pp. 7, 8)

The study includes information gathered from 150 executives chosen from *Fortune*'s list of large corporations. These executives represented a variety of financial, industrial, and service industries. Half of the group were interviewed and the other half responded to an open-ended questionnaire.

Dr. Kiev is most sensitive to the demands of external reality placed upon the executive, e.g., the need to generate capital, the role of government regulatory agencies in determining corporate policy, the need to respond to customer demands, and the need to deal with competitors. At the same time, he expresses the importance of the executive's developing insight into his internal needs, to defend against strong impulses. Kiev reemphasizes the difficulty executives have in coping with anger, greed, envy, ambiguity, loneliness, and guilt—feelings that all individuals have trouble dealing with at various times.

Jourard focused on the inability of the corporate man to adequately discharge feelings in an organizational setting in a paper titled "Some Lethal Aspects of the Male Role" (4). He stated that this inability results in a variety of psychopathological reactions. Dr. Kiev discusses various types of self-defeating behavior (e.g., too many meetings, an open-door policy) designed to avoid or delay important decisions. He mentions what needs to be emphasized in any book on the subject of executive stress—the classic soft signs of depression—to alert the executive to the subtle symptoms of stress. Kiev's brief chapters on corporate limitations, the management of men, the mechanism and difficulty of change, and the stress of firing and retirement provide some valuable insights for the executive.

In spite of the cogent insights in this book, there are some major flaws that should be noted. Although I can identify in spirit with what Kiev is trying to say, some of the statements are nevertheless too generalized and unrealistic, e.g., "The older executive shouldn't be afraid of competition from the more active junior, who may be destined for a greater responsibility and may some day repay him for his support" and "The middle manager must learn to transmit *all* information, good and bad, to his supervisor."

For reasons that are unclear, Kiev distinctly separates the executive from the middle manager. It seems to me that a middle manager could be an executive as well. There is also no significant discussion of the female or black executive—two groups that face unique stress reactions in organizational life.

Because this book appears to be written primarily for the executive, mention should be made of specific strategies for dealing with stress, including a regular regimen of exercise and relaxing habits. The recent techniques used in the treatment of stress, including transcendental meditation, autohypnosis, biofeedback, progressive muscular relaxation, and a host of other behavioral techniques, are not discussed. There is also no specific bibliography to further assist the reader.

This book emphasizes the need for primary prevention in dealing with stress, a concept that almost everyone agrees with but few practice. As Kiev states,

> Executives and managers must learn how to avert the accumulation of tensions by developing habits of self-reliance, self-control, goal direction, avoidance of argument or overreaction to the behavior of others and the acceptance of responsibility for self. (p. 169)

One hopes that this useful book will serve as a catalyst for further exploration and will be read not only by the executive but by those physicians who treat executives in the corporate complex.

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1. Levinson H: Executive Stress. New York, Harper & Row, 1970
2. Kearns LJ: Stress in Industry. London, Priory Press, 1973
3. McLean A (ed): Organizational Stress. Springfield, Ill, Charles C Thomas, 1974
4. Jourard S: The Transparent Self. Toronto, D Van Nostrand Co, 1964, pp 46–55

BARRIE SANFORD GREIFF, M.D.
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Anticipatory Grief, *edited by Bernard Schoenberg, Arthur C. Carr, Austin H. Kutscher, David Peretz, and Ivan K. Goldberg. New York, N.Y., Columbia University Press, 1974, 374 pp., $12.50.*

This is another of the rapidly produced symposia sponsored by the Foundation of Thanatology. Fifty-nine authors contributed 41 chapters addressed to the topic of anticipatory grief. Only two of the authors, Reed and Nolan, allude to the fact that grief is a response to all separations and not only to the loss of a loved one. I would suggest that grief and the expression of the mental part of grief, mourning, are responses to any actual or threatened loss or separation, i.e., loss of a loved one, position, a possession, or a body part, aging, dying, graduation from high school or college, children leaving for school, retirement, loss of finances or social position, illegitimate pregnancy of a daughter, or the end of a particularly good book.

The pertinent issue of whether or not anticipatory grieving obviates or alleviates conventional mourning after the loss is not answered satisfactorily in any of these articles, although Silverman, in her chapter "Anticipatory Grief from the Perspective of Widowhood," thinks not. Her data indicate that widows who had been aware of their husband's terminal illness did not grieve in advance.

There is disagreement on interpretation throughout this volume. The appendix is a chapter on terminology, meaning, use, and connotations of "anticipatory grief." Definitions are offered by the various medical, paramedical, and theological disciplines. There are eight different views written by psychiatrists.

This book is a veritable potpourri with something for everyone. There are six major sections: Introductory Concepts, in which Aldrich's chapter on dynamics is worthwhile, Clinical Aspects, Childhood Illness, in which Brenda Comerford's chapter recalling her loss of a child and giving recommendations for parents and professionals is interesting, The Health Professions, The Mangement of Anticipatory Grief, and Pastoral Aspects.

I can give this work only a limited recommendation. Those who find a particular section appealing will perhaps read that section. As in any symposium, the material is irregular in style and content. The reader has the sensation that an explosion of intellectualizations and verbiage has been set off. It seems to me that a monograph would be more appropriate to the topic of anticipatory grief. In fact, two complementary articles would suffice to supersede this book: Fulton and Fulton's article (1), which was published in a previous volume of the Foundation of Thanatology, and Berezin's article (2), which is not included in any of the chapter references in the book under review.

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1. Fulton R, Fulton J: Anticipatory grief: a psychosocial aspect of terminal care, in Psychosocial Aspects of Terminal Care. Edited by Schoenberg B, Carr AC, Peretz D, et al. New York, Columbia University Press, 1972, pp 227–242
2. Berezin MA: Partial grief in family members and others who care for the elderly patient. J Geriatr Psychiatry 4:53–64, 1970

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Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

New Dimensions in Psychiatry: A World View, *edited by Silvano Arieti, M.D., and Gerard Chrzanowski, M.D. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1975, 427 pp., $22.95.*

Advocacy for Child Mental Health, *edited by Irving N. Berlin, M.D. New York, N.Y., Brunner/Mazel, 1975, 333 pp., $13.50.*

And a Time To Dance, *2nd ed., by Norma Canner. Boston, Mass., Plays, 1975, 144 pp., $6.95.*

Artificial Paranoia: A Computer Simulation of Paranoid Processes, *by Kenneth Mark Colby, M.D. New York, N.Y., Pergamon Press, 1975, 197 pp., $12.50; $7.50 (paper).*

Children and Dying: An Exploration and Selective Bibliographies, *2nd ed., by Sarah Sheets Cook, R.N., and others, compiled and edited by Roberta Halporn. New York, N.Y., Health Sciences Publishing Corp., 1974, 106 pp., no price listed (paper).*

T-Groups: A Survey of Research, *edited by C.L. Cooper and I.L. Mangham. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1975, 273 pp., $5.95 (paper).*

The Stigmata of Dr. Constantine, *by Tom Dulack. New York, N.Y., Harper's Magazine Press (in association with Harper & Row), 1975, 293 pp., $8.95.*

The Superficial Veins of the Human Brain: Veins of the Brain Stem and of the Base of the Brain, *by Henri M. Duvernoy. New York, N.Y., Springer-Verlag, 1975, 107 pp., $36.10.*

Beyond Drugs, *by Stanley Einstein, Ph.D. New York, N.Y., Pergamon Press, 1975, 286 pp., $12.00; $7.00 (paper).*

Speaking of Children: Their Learning Abilities/Disabilities, *by Careth Ellingson. New York, N.Y., Harper & Row, 1975, 275 pp., $8.95.*

Introduction to Contemporary Psychology, *by Edmund Fantino and George S. Reynolds. San Francisco, Calif., W.H. Freeman and Co., 1975, 590 pp., $12.95.*

Behavior Principles, *2nd ed., by C.B. Ferster, Stuart Culbertson, and Mary Carol Perrott Boren. Englewood Cliffs, N.J., Prentice-Hall, 1975, 679 pp., $12.95.*

The Psychoanalysis of War, *by Franco Fornari, translated by Alenka Pfeifer. Bloomington, Ind., Indiana University Press, 1975, 270 pp., $10.00.*

I, Pierre Rivière, Having Slaughtered My Mother, My Sister, and My Brother: A Case of Parricide in the 19th Century, *edited by Michel Foucault, translated by Frank Jellinek. New York, N.Y., Pantheon Books (Random House), 1975, 288 pp., $10.00.*

Basic Approaches to Group Psychotherapy and Group Counseling, *2nd ed., edited by George M. Gazda. Springfield, Ill., Charles C Thomas, 1975, 510 pp., $16.75.*

The Experience of Anxiety: A Casebook, *2nd ed., by Michael J. Goldstein, Ph.D., and James O. Palmer, Ph.D. New York, N.Y., Oxford University Press, 1975, 294 pp., $3.95 (paper).*

Human Sexuality: A Health Practitioner's Text, *edited by Richard Green, M.D. Baltimore, Md., Williams & Wilkins Co., 1975, 245 pp., $14.50.*

The Care and Training of the Mentally Handicapped: A Manual for the Caring Professions, *by Charles H. Hallas, S.R.N., William I. Fraser, M.D., and Ronald C. MacGillivray, M.B., D.P.M. Bristol, England, John Wright and Sons (Baltimore, Md., Williams & Wilkins, exclusive U.S. distributor), 1974, 269 pp., $18.75.*

Survival in Society, *by Eugene Heimler. New York, N.Y., Halsted Press (John Wiley & Sons), 1975, 154 pp., $7.95.*

Police Wife: How To Live with the Law and Like It, *by Pat James and Martha Nelson. Springfield, Ill., Charles C Thomas, 1975, 119 pp., $11.50.*

Sex Education and Counseling of Special Groups: The Mentally and Physically Handicapped, Ill and Elderly, *by Warren R. Johnson, Ed.D. Springfield, Ill., Charles C Thomas, 1975, 210 pp., $12.50.*

A Primer of Drug Action, *by Robert M. Julien. San Francisco, Calif., W.H. Freeman and Co., 1975, 281 pp., $10.00; $4.95 (paper).*

New Treatment Approaches to Juvenile Delinquency, *edited by J.L. Khanna, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 143 pp., $11.75.*

The Integration of Child Psychiatry Into the Basic Residency Program, *edited by Leo Madow, M.D., and Charles A. Malone, M.D. Hillsdale, N.J., Town House Press, 1975, 115 pp., no price listed.*

Métapsychiatrie, *by Pierre Marchais. Paris, France, Masson et Cie, 1974, 111 pp., 60 French francs (paper).*

Neuropsychiatry in World War II, vol. II: Overseas Theaters, *by the Medical Department, United States Army. Washington, D.C., Office of the Surgeon General, Department of the Army (Publication 0832-00047, U.S. Government Printing Office), 1973, 1,094 pp., $16.20.*

A Handbook for the Study of Suicide, *edited by Seymour Perlin, M.D. New York, N.Y., Oxford University Press, 1975, 226 pp., $9.95; $5.95 (paper).*

Music Therapy in Action, *by Mary Priestley. New York, N.Y., St. Martin's Press, 1975, 268 pp., $10.00.*

Psychology in Progress: Readings from the Scientific American. *San Francisco, Calif., W.H. Freeman and Co., 1975, 385 pp., $12.00; $6.25 (paper).*

The Psychology Primer. *Solana Beach, Calif., Publisher's (New York, N.Y., Dell Distributing, distributor), 1975, 237 pp., $3.95 (paper).*

What's Wrong with the Mental Health Movement, *by K. Edward Renner, Ph.D. Chicago, Ill., Nelson-Hall, 1975, 214 pp., $11.00.*

Mental Retardation: A Handbook for the Primary Physician, *2nd ed., edited by Julius B. Richmond, M.D., George Tarjan, M.D., and Robert S. Mendelsohn, M.D. Chicago, Ill., American Medical Association, 1974, 128 pp., $2.00 (paper).*

Patient Care Evaluation in Mental Health Programs, *edited by Donald C. Riedel, Gary L. Tischler, and Jerome K. Myers. Cambridge, Mass., Ballinger Publishing Co. (J.B. Lippincott Co.), 1974, 287 pp., no price listed.*

Planning Urban Health Services: From Jungle to System, *by Ruth Roemer, Charles Kramer, and Jeanne E. Frink. New York, N.Y., Springer Publishing Co., 1975, 344 pp., $12.50; $6.95 (paper).*

Community Mental Health Programs in England: An American View, *by Norman Rosenzweig, M.D. Detroit, Mich., Wayne State University Press, 1975, 264 pp., $13.95.*

A Strange Breed of Cat (An Encounter in Human Sexuality), *by B. Mark Schoenberg. Homewood, Ill., ETC Publications, 1975, 325 pp., $10.50.*

Rape Victimology, *edited by Leroy G. Schultz. Springfield, Ill., Charles C Thomas, 1975, 405 pp., $28.00.*

Hopelessness: On Depression, Development, and Death, *by Martin E.P. Seligman. San Francisco, Calif., W.H. Freeman and Co. (New York, N.Y., Charles Scribner's Sons, trade distributor), 1975, 235 pp., $8.95; $4.95 (paper).*

Evaluation of Treatments. Studies of the Effectiveness of Treatments for Drug Abuse, vol. I, *edited by S.B. Sells. Cambridge, Mass., Ballinger Publishing Co. (J.B. Lippincott Co.), 1974, 534 pp., $18.50.*

Research on Patients, Treatments and Outcomes. Studies of the Effectiveness of Treatments for Drug Abuse, vol. II, *edited by S.B. Sells. Cambridge, Mass., Ballinger Publishing Co. (J.B. Lippincott Co.), 1974, 418 pp., $16.50.*

The Experience of Introversion: An Integration of Phenomenological, Empirical, and Jungian Approaches, *by Kenneth Joel Shapiro and Irving E. Alexander. Durham, N.C., Duke University Press, 1975, 177 pp., $8.75.*

Contemporary Psychiatry: Selected Reviews from the British Journal of Hospital Medicine, *edited by Trevor Silverstone and Brian Barraclough. London, England, British Journal of Psychiatry (Ashford, Kent, England, Invicta Press, Headley Brothers, distributor), 1975, 466 pp., $15.00 (paper).*

Kompendium der Psychiatrie, *by Theodor Spoerri. New York, N.Y., S. Karger, 1975, 239 pp., $10.25 (paper).*

Self Psychotherapy, vol. 1, *by Albert V. Steinkirchner, M.D. Venice, Calif., Aquin Publishing Co., 1975, 159 pp., no price listed.*

Heroin Dependency: Medical, Economic and Social Aspects, *by Barry Stimmel, M.D. New York, N.Y., Stratton Intercontinental Publishing Corp., 1975, 294 pp., $27.00.*

Is It Well with the Child? A Parent's Guide to Raising a Mentally Handicapped Child, *by Susan Strauss. Garden City, N.Y., Doubleday & Co., 1975, 152 pp., $7.95.*

Why Did You Do That? Rainy Day Games for a Post-Industrial Society, *by E. Fuller Torrey, M.D. Radnor, Pa., Chilton Book Co., 1975, 198 pp., $7.95.*

Behavior Modification with Children: A Clinical Training Manual, *by Alexander J. Tymchuk, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 129 pp., $9.75; $6.95 (paper).*

Ivory Fortress: A Psychiatrist Looks at West Point, *by Richard C. U'Ren, M.D. Indianapolis, Ind., Bobbs-Merrill Co., 1974, 156 pp., $6.95.*

Psychotherapy and Psychoanalysis: Theory, Practice, Research, *by Robert S. Wallerstein. New York, N.Y., International Universities Press, 1975, 465 pp., $17.50.*

Personality Development and Deviation: A Textbook for Social Work, *edited by George H. Weideman, M.D., and Sumner Matison, M.A., M.S.S.W. New York, N.Y., International Universities Press, 1975, 499 pp., $20.00.*

Principles of Psychotherapy, *by Irving B. Weiner. New York, N.Y., Wiley-Interscience (John Wiley & Sons), 1975, 318 pp., $15.95.*

Pharmacological Testing in a Correctional Institution: Volunteer Characteristics and Motivations; Social, Psychological and Attitudinal Implications, *by Stephen H. Wells, LL.B., M.A., Patricia M. Kennedy, M.A., John Kenny, M.A., Marvin Reznikoff, Ph.D., and Michael H. Sheard, M.D. Springfield, Ill., Charles C Thomas, 1974, 58 pp., $7.75.*

Absenteeism in Industry, *by Stanley F. Yolles, M.D., Pasquale A. Carone, M.D., and Leonard W. Krinsky, Ph.D. Springfield, Ill., Charles C Thomas, 1974, 130 pp., $11.50.*

OFFICIAL ACTIONS

The American Board of Psychiatry and Neurology

The following are those who successfully completed the Board examination given in Atlanta, Ga., Feb. 3–4, 1975.

PSYCHIATRY

Abdel-Messih, Nazmi Yacoub, M.D., Kings Park, N.Y.
Ager, Harvey Gerald, M.D., Woodland Hills, Calif.
Anderson, John W., M.D., Lawrenceville, N.J.
Arensdorf, Alfred M., M.D., Honolulu, Hawaii
Auster, Rosalie M., M.D., Washington, D.C.

Barbanel, Charles Joseph, M.D., New York, N.Y.
Benitez, Jose-Luis, M.D., Paramus, N.J.
Bennett, Mona Bleiberg, M.D., Brookline, Mass.
Berger, Howard Stephen, M.D., Needham, Mass.
Biron, Roger, M.D., Drummondville, Que., Canada
Bloch, Sheldon F., M.D., Los Angeles, Calif.
Bond, Thomas Cannon, M.D., Belmont, Mass.
Bowen, Malcolm Garry, M.D., Newton, Conn.
Brada, Donald R., M.D., Colorado Springs, Colo.
Branchey, Marc Henri, M.D., Englewood, N.J.
Bredenberg, Willard Alfred, M.D., West Chester, Pa.
Brown, Donald Benjamin, M.D., New York, N.Y.
Bulette, John L., M.D., Philadelphia, Pa.
Burstein, Allan, M.D., New York, N.Y.
Butt, M. Munawar, M.D., Muskegon, Mich.

Camp, Norman Marshall, M.D., San Francisco, Calif.
Campbell, Donald Ross, M.D., Signal Mountain, Tenn.
Canapary, Leon J., M.D., Rochester, N.Y.
Cassem, Edwin H., M.D., Cambridge, Mass.
Caudle, John Allen, M.D., Charlotte, N.C.
Chaitman, Edmund, M.D., Tenafly, N.J.
Chamberlain, Terry J., M.D., San Francisco, Calif.
Charles, Steven T., M.D., Manhattan Beach, Calif.
Chou, Shingsan, M.D., Staten Island, N.Y.
Ciccone, J. Richard, M.D., Rochester, N.Y.
Coleman, Stephen J., M.D., Sands Point, N.Y.
Collins, Allen Howard, M.D., New York, N.Y.
Coons, Richard E., M.D., Austin, Tex.
Craig, Thomas J., M.D., Chevy Chase, Md.

Dale, John Wesley, M.D., Houston, Tex.
Denker, Martin W., M.D., Tampa, Fla.
Desaloms, Armando, M.D., Arlington, Tex.
Dickes, Richard A., M.D., Morristown, N.J.
Dolan, John Patrick, M.D., Webster Grove, Mo.

Eiland, David Chase, Jr., M.D., Galveston, Tex.
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Emerson, Deanna Doro, M.D., Houston, Tex.
Erickson, Harold M., Jr., M.D., Lubbock, Tex.

Farley, Arthur J., M.D., Los Angeles, Calif.
Farrer, Richard James, M.D., Nashville, Tenn.

Feiner, Joel S., M.D., New York, N.Y.
Fiks, Juan Bernardo, M.D., Tenafly, N.J.
Flicker, Marvin, M.D., Beverly Hills, Calif.
Follett, William W. III, M.D., El Paso, Tex.
Fowler, Richard C., M.D., Iowa City, Iowa
Fried, Frederick Elliot, M.D., Columbia, Mo.

Gaskin, Fred Wayne, M.D., St. Louis, Mo.
Gershell, William Jay, M.D., New York, N.Y.
Gilbert, Roberta M., M.D., Leawood, Kans.
Glanzberg, Carol, M.D., Oyster Bay, N.Y.
Glassman, Alexander H., M.D., Teaneck, N.J.
Godbole, Anil, M.D., Chicago, Ill.
Goetzl, Ugo, M.D., Hershey, Pa.
Gold, Sidney, M.D., Granada Hills, Calif.
Goldstein, William N., M.D., Rockville, Md.
Gottesman, David M., M.D., Delmar, N.Y.
Greden, John Francis, M.D., Ann Arbor, Mich.

Hall, David A., M.D., S. Pasadena, Calif.
Hall, Richard Chaloner Winton, M.D., Merrit Island, Fla.
Hammerman, Jeffrey L., M.D., Melville, N.Y.
Haney, Renee, M.D., Tampa, Fla.
Hebert, Frederick B., M.D., Westminster, Colo.
Heiman, Peter L., M.D., Cincinnati, Ohio
Heller, Stanley Samuel, M.D., Tenafly, N.J.
Helzer, John E., M.D., St. Louis, Mo.
Hidley, John H., M.D., Fairfield, Calif.
Hirschfeld, Robert M. A., M.D., Bethesda, Md.
Hopper, John J., Jr., M.D., Evergreen, Colo.
Hopson, Patricia C., M.D., Detroit, Mich.
Hutzinger, James A., M.D., Norristown, Pa.

Ianzito, Benjamin M., M.D., Long Meadow, Mass.

Jacobs, Bernard J., M.D., Brooklyn, N.Y.
Jaeckle, Richard G., M.D., Chesterfield, Mo.
Jenkins, Chester Wright, M.D., Opelika, Ala.
Jeppsen, E. Alan, M.D., Salt Lake City, Utah
Jordan, James J., M.D., Minneapolis, Minn.
Joy, Michael Fieldings, M.D., St. Louis, Mo.

Kahn, James Leslie, M.D., Fitchburg, Mass.
Kantack, Paul W., M.D., Biloxi, Miss.
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Kellermann, Sara L., M.D., Riverdale, N.Y.
Kentsmith, David K., M.D., Springfield, Neb.
Ketai, Richard, M.D., Ann Arbor, Mich.
Killingsworth, Roy Neil, M.D., Tucson, Ariz.
Kraft, David P., M.D., Amherst, Mass.

Krell, Ted William, M.D., Baytown, Tex.
Kuhs, Leon, M.D., Glencoe, Ill.
Kumar, K. M. Druva, M.D., Troy, Mich.

Lampertz, Gitta W., M.D., Postfach 540, Germany
Lerner, Robert D., M.D., Cincinnati, Ohio
Levey, Stephen G., M.D., New York, N.Y.
Levin, Michael H., M.D., Walnut Creek, Calif.
Liebson, Ira Allen, M.D., Baltimore, Md.
Lifschutz, David H., M.D., Los Angeles, Calif.
Lipp, Martin R., M.D., San Francisco, Calif.

Maier, William J., M.D., Jamesville, N.Y.
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Marshall, Benton H., M.D., Philadelphia, Pa.
Matthews, Daniel T., M.D., Austin, Tex.
McCabe, Michael S., M.D., Iowa City, Iowa
McCollum, Mary B., M.D., Houston, Tex.
McGehee, James Bartley, M.D., Nashville, Tenn.
McMurrer, James P., M.D., Washington, D.C.
McNutt, Edith R., M.D., San Francisco, Calif.
McReynolds, Edwards U., M.D., Sugarland, Tex.
Meisel, Frederick L., M.D., Cambridge, Mass.
Meissner, William W., M.D., Cambridge, Mass.
Metzger, Carl P., M.D., APO N.Y.
Molchon, Andrew B., M.D., Washington, D.C.
Moran, Thomas Michael, M.D., St. Louis, Mo.
Moscotti, Richard W., M.D., Philadelphia, Pa.
Mueller, Barbara Campbell, M.D., Newton Center, Mass.

Nadel, William Roberts, M.D., Hastings-On-Hudson, N.Y.
Najam, Abdur Rehman, M.D., North Platt, Neb.
Noh, Kyung Sun, M.D., Bronx, N.Y.
Nurnberg, H. George, M.D., New York, N.Y.

O'Byrne, Natalie K., M.D., San Anselmo, Calif.
Olds, David D., M.D., New York, N.Y.
Olen, David J., M.D., Pontiac, Mich.

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Penick, Sydnor B. III, M.D., Princeton, N.J.
Peterson, Gerald C., M.D., Rochester, Minn.
Pfeffer, Cynthia R., M.D., New York, N.Y.
Phillips, Arthur, M.D., New York, N.Y.
Pinta, Emil Richard, M.D., Worthington, Ohio
Potts, Robert C., M.D., Bryan, Tex.
Prats, Violeta T., M.D., Philadelphia, Pa.
Preston, Thomas E., M.D., Beverly Hills, Calif.

Rahm, Alan S., M. D., Brooklyn, N.Y.
Rankin, Diane, M.D., St. Louis, Mo.
Rauenhorst, John Moir, M.D., St. Paul, Minn.
Reilly, Francis E., M.D., New Haven, Conn.
Rieder, Ronald O., M.D., Reston, Va.
Ringold, Alan L., M.D., Palo Alto, Calif.
Roberge, Leo A., M.D., Tacoma, Wash.
Robertson, Gerald Melvin, M.D., Hattiesburg, Miss.
Rodgers, John C., Jr., M.D., Knoxville, Tenn.
Ryan, Patrick J., M.D., Camarillo, Calif.
Rynearson, Edward King, M.D., Seattle, Wash.

Safier, Josef, M.D., Dix Hills, N.Y.
Santiago y Ruiz De Porras, Carlos R., M.D., High Bridge, N.J.
Sastry, Maheshchandra G., M.D., West Brentwood, N.Y.
Savadove, Robert Franklin, M.D., Portland, Maine
Schatzberg, Alan F., M.D., Belmont, Mass.
Schick, Jane, M.D., New York, N.Y.
Schmidt, L. J., M.D., Salt Lake City, Utah
Schott, John William, M.D., Dover, Mass.
Sears, Victoria C., M.D., Great Neck, N.Y.
Secrist, Delbert L., Jr., M.D., Solan Beach, Calif.
Selzer, Joae Graham, M.D., Brookline, Mass.
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Sheridan, Sylvester R., M.D., Wollaston, Mass.
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Tennebaum, Arthur S., M.D., Chicago, Ill.
Trager, Eugene P., M.D., Skokie, Ill.
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Tugana, Brian E., M.D., Rockford, Ill.
Turner, David Avery, M.D., Portland, Ore.
Tuthill, Edward W., M.D., Dallas, Tex.

Vanderschraaf, Anna H., M.D., Morris Plains, N.J.
VanRheenen, Frederic J., M.D., Palo Alto, Calif.

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Wells, Charles E., M.D., Nashville, Tenn.
Wilf, Theodore J., M.D., APO N.Y.
Wolf, Elliott Michael, M.D., Evergreen, Colo.
Wood, Paul Edward, M.D., Huntington Beach, Calif.
Wu, Haw Chyr, M.D., Cleveland, Ohio

Young, John Gerald, M.D., Woodbridge, Conn.

Zinn, Lynwood David, M.D., Ann Arbor, Mich.
Zitner, George L., M.D., Pittsburgh, Pa.

NEUROLOGY

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Burkholder, James D., M.D., Columbus, Ohio

Cuetter, Albert C., M.D., Fort Jackson, S.C.
Culebras, Antonio, M.D., Madrid, Spain

Dapra, David J., M.D., Reno, Nev.
Davis, James N., M.D., Durham, N.C.
Devereaux, Michael W., M.D., Turnersville, N.J.
Feldman, Martin H., M.D., Larchmont, N.Y.
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Gale, Matthew K., M.D., Berkeley, Calif.
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Gilliland, Robert L., M.D., Youngstown, Ohio
Good, Edward F., M.D., Houston, Tex.
Gosink, Leonard J., M.D., San Diego, Calif.

Hall, James H. III, M.D., Virginia Beach, Va.

Haworth, Chester C., Jr., M.D., High Point, N.C.
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Rosenberg, Jay H., M.D., La Jolla, Calif.
Rothstein, Ted L., M.D., Seattle, Wash.

Salanga, Virgilio D., M.D., Shaker Heights, Ohio
Sanzenbacher, Karl E., M.D., Waterville, Maine
Schraeder, Paul L., M.D., Dalton, Mass.
Selby, Richard N., M.D., Santa Ana, Calif.
Slater, Robert, M.D., Havertown, Pa.
Spilsbury, Paul R., M.D., San Diego, Calif.
Su, Philip C. C., M.D., Dix Hills, N.Y.
Swerdlow, Michael L., M.D., Philadelphia, Pa.

Toro, Rodrigo, M.D., Towson, Md.
Troiano, Raymond, M.D., West New York, N.J.

Weisberg, Leon A., M.D., New Orleans, La.
Woods, Bryan T., M.D., Wellesley, Mass.

CHILD NEUROLOGY

Bird, Morris T., M.D., Birmingham, Ala.
Eisengart, Marvin A., M.D., Waterville, Maine
Gumbinas, Maria, M.D., Chicago, Ill.
Meloff, Keith Lyon, M.D., Toronto, Ont., Canada

Murphy, Jerome V., M.D., Pittsburgh, Pa.
Rosenblum, Edwin L., M.D., Albany, N.Y.
Sullivan, Leo R., M.D., Swampscott, Mass.
Victor, David Ira, M.D., Baltimore, Md.

The following are those who successfully completed the Board examination given in Atlanta, Ga., March 2–4, 1975.

CHILD PSYCHIATRY

Altman, Michael Albert, M.D., Denver, Colo.
Anderson, Maxine Karen, M.D., Seattle, Wash.
Armitage, David Templeton, M.D., Augusta, Ga.

Berenson, Claudia K., M.D., Salt Lake City, Utah
Berman, Merrill I., M.D., Baltimore, Md.
Bernet, F. William, M.D., Washington, D.C.
Bernstein, Dorothy M., M.D., Minneapolis, Minn.
Boylston, William Harrison, M.D., Houston, Tex.

Clark, Corydon G., M.D., Carmichael, Calif.
Cohen, Barbara, M.D., San Bruno, Calif.

Dowling, Patrick J., M.D., New Orleans, La.

Eckhardt, Lloyd O., M.D., Denver, Colo.
Egan, James, M.D., Pelham, N.Y.
El-Rafei, Nabil, M.D., River Vale, N.J.

Goldstein, Harris S., M.D., Staten Island, N.Y.
Goodman, Beverly Hallquist, M.D., Great Neck, N.Y.
Grosso, Joseph Xavier, M.D., Hillsdale, N.J.

Haslett, Nancy Rose, M.D., New Orleans, La.
Hauser, Charles Edward, M.D., Colorado Springs, Colo.
Hertzig, Margaret E., M.D., New City, N.Y.
Hill, Fontaine S., M.D., Memphis, Tenn.

Jaffe, Steven L., M.D., Dunwoody, Ga.

Kestenbaum, Clarice J., M.D., New York, N.Y.

Lambert, Dennis Michael, M.D., Lake Bluff, Ill.
Lecker, Sidney, M.D., Suffern, N.Y.
Lewis, Ronel L., M.D., Columbus, Ga.
Lipsig, Stephen, M.D., Roslyn, N.Y.

Mazor, Miriam Dushman, M.D., Brookline, Mass.
Meyer, Anthony David, M.D., Pewaukee, Wis.
Modarressi, Taghi M., M.D., Baltimore, Md.

Perkins, Robert James, M.D., Los Angeles, Calif.

Ravenscroft, Kent, Jr., M.D., Washington, D.C.
Ritter, Baird Stuart, M.D., Bryn Mawr, Pa.

Roth, Edwin I., M.D., Shaker Heights, Ohio
Rumore, Franklin A., M.D., San Jose, Calif.
Rusk, John M., M.D., Ardmore, Pa.
Russak, Sidney, M.D., Rivera, Calif.

Saviano, Carl, M.D., Westfield, Mass.
Seligman, Roslyn, M.D., Cincinnati, Ohio
Semonsky, Charles J., M.D., Atlanta, Ga.
Shatkin, Eugene Parker, M.D., San Rafael, Calif.
Sheff, Lawrence, M.D., New Hyde Park, N.Y.
Stearns, Sheldon Edward, M.D., Scarsdale, N.Y.
Stein, Arthur H., M.D., Gaithersburg, Md.

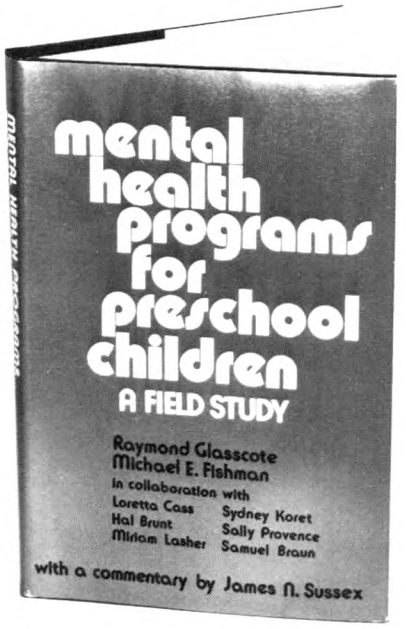
Tendero, Emmanuel M., M.D., Southfield, Mich.

Wang, Ging-Long, M.D., Berkeley, Calif.
Warm, Theodore Reeves, M.D., Lyndhurst, Ohio
West, Gerard M., M.D., Gaithersburg, Md.
White, James Harrison, M.D., Galveston, Tex.
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A Timely New Book from The Joint Information Service

This latest Joint Information Service field study provides a concise, comprehensive overview of the complex matter of the very young American child and his mental health, and then describes in intimate detail seven unique programs for pre-school children with problems—from North Hollywood's Dubnoff Center, emphasizing education as its primary therapeutic modality, to Baltimore's Martin Luther King, Jr. Parent-Child Center, serving two housing projects, served by Johns Hopkins, and largely governed by its own people. All different in treatment approach and philosophy, the programs described are uniform in their dedication to innovation in improving service to the emotionally disturbed very young child, and, equally, to the emotional well being of all young children.

This thoughtful and perceptive description of what has been created by some of the best informed, most experienced and thoughtful specialists in mental health services for very young children should be welcome to all involved in the mental health of children and a casebook for those dealing with child and family mental health.



An articulate exposition of the immense problems and encouraging accomplishments in a particularly difficult area of endeavor . . . . Beyond their concern with the manifestly ill child, the authors intriguingly explore what may be needed to enhance the mental good health of all young children . . . . A significant contribution.

James N. Sussex, M.D.
President, American Association of Psychiatric Services for Children

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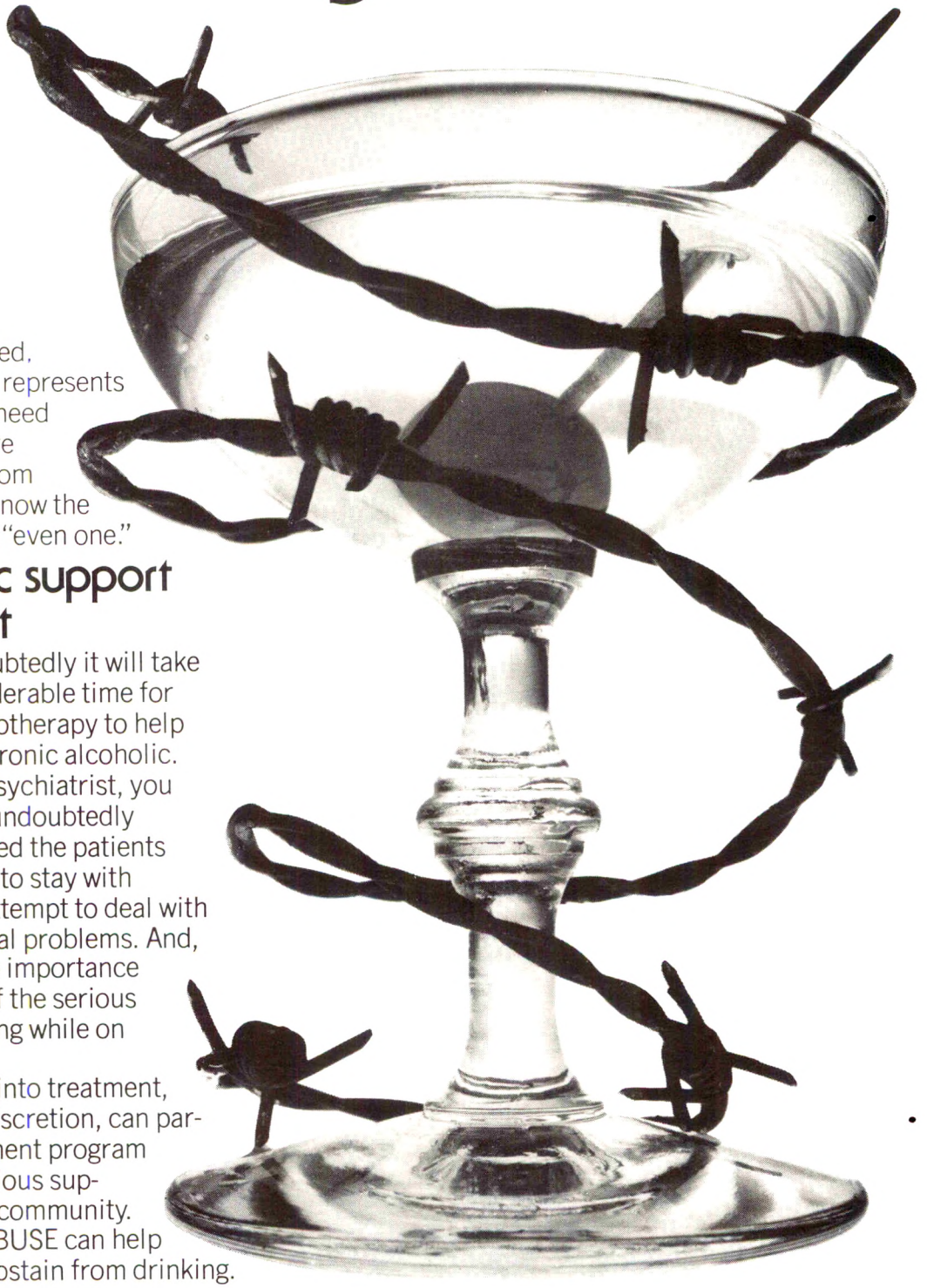
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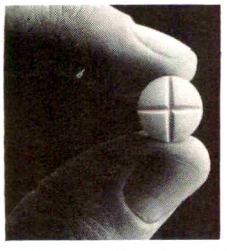
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ANTABUSE: "Social security" for the alcoholic who wants to stop drinking...



The temptation is resisted. ANTABUSE (disulfiram) represents the security alcoholics need in any situation. They are better able to abstain from drinking because they know the consequences of taking "even one."

until psychiatric support can do the rest



Undoubtedly it will take considerable time for psychotherapy to help the chronic alcoholic. As a psychiatrist, you have undoubtedly selected the patients who are best motivated to stay with ANTABUSE while you attempt to deal with the underlying emotional problems. And, of course, you know the importance of reminding patients of the serious consequences of drinking while on ANTABUSE.

Once sober, and well into treatment, the alcoholic, at your discretion, can participate in a total treatment program which makes use of various supportive resources in the community. In the meantime, ANTABUSE can help the chronic alcoholic abstain from drinking.

BRIEF SUMMARY
(For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) in Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, *e.g.* cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE (disulfiram) should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE (disulfiram), report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.) and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

AYERST LABORATORIES
New York, N.Y. 10017

Ayerst®

7461

ANTABUSE®
BRAND OF DISULFIRAM

in clinically significant depression...

penetrating the symptom barrier to productive psychotherapy

symptoms often interfere with therapy

In clinically significant depression, the patient often becomes barricaded behind his own symptoms during psychotherapy. Because these symptoms can be so sharply defined and somatic in expression, he may reject the fact that they are psychic in origin. Sleep disturbance, gastrointestinal complaints, anorexia, chronic fatigue, and other psychosomatic symptoms may so preoccupy—or overwhelm—the depressed patient that truly productive therapeutic sessions are difficult to achieve. Instead of being able to concentrate on the core emotional problems of the depression itself, he may for example go on at length about how broken his sleep is or keep reiterating (while the therapeutic hour slips by) how physically miserable he feels.

ELAVIL®
(AMITRIPTYLINE HCl, MSD)
to help penetrate the symptom barrier in depression requiring medication

ELAVIL, a highly effective tricyclic antidepressant, will often alleviate these symptoms. With the help of ELAVIL, sleep disturbance—so common in clinically depressed patients and often the symptom that distresses them most—as



well as other "barrier symptoms" may be lessened to the point where they no longer come between you and the patient.

psychotherapy takes direction

As these preoccupying complaints are lifted, psychotherapy sessions can become more productive. Patients are enabled to respond more fruitfully during therapeutic hours and to resume or pursue more efficiently the necessary activities in their personal lives.

meeting therapeutic goals

And as the antidepressant activity of ELAVIL (Amitriptyline HCl, MSD) takes hold, it helps relieve the depressive condition itself. Sometimes only a minimum of actual psychotherapy is required. The patient may experience a more rapid recovery—while you conserve valuable time.

Prescribe ELAVIL then, to help lighten the patient's burden in depression—and yours in its management.

Should not be used during the acute recovery phase following myocardial infarction; in patients hypersensitive to it; in those who have received an MAOI within two weeks; or in children under 12. Patients with cardiovascular disorders should be watched closely. Safe use during pregnancy and lactation has not been established. The drug may impair mental or physical abilities required in the performance of hazardous tasks and may enhance the response to alcohol. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps increase your effectiveness in managing clinically significant depression



MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please see following page.

MSD
MERCK
SHARP &
DOHME

addendum

In adult outpatients
with clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

once a day AT BEDTIME or **divided dosage** DAILY

25 mg (yellow)



This tablet may prove useful for initial therapy in adult outpatients. Starting dosage is usually 75 mg daily in divided doses or 50 to 100 mg once a day at bedtime. If necessary, this dosage may be increased gradually to a total of 150 mg a day. When doses are divided, dosage increases are made preferably in the late afternoon or at bedtime. A sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be advantageous whenever higher dosages are required, or when the single daily dose is given at bedtime. The 50-mg tablet may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher doses.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure; in patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.
When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: Hospitalize as soon as possible all patients suspected of having taken an overdose. Treatment is symptomatic and supportive. In addition, the intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

ELAVIL
(AMITRIPTYLINE HCl, MSD)

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Evaluative Methods in Psychiatric Education

A New Publication of the American Psychiatric Association

Editors: Hyman L. Muslin, M.D.
Robert J. Thurnblad, M.D.
Bryce Templeton, M.D.
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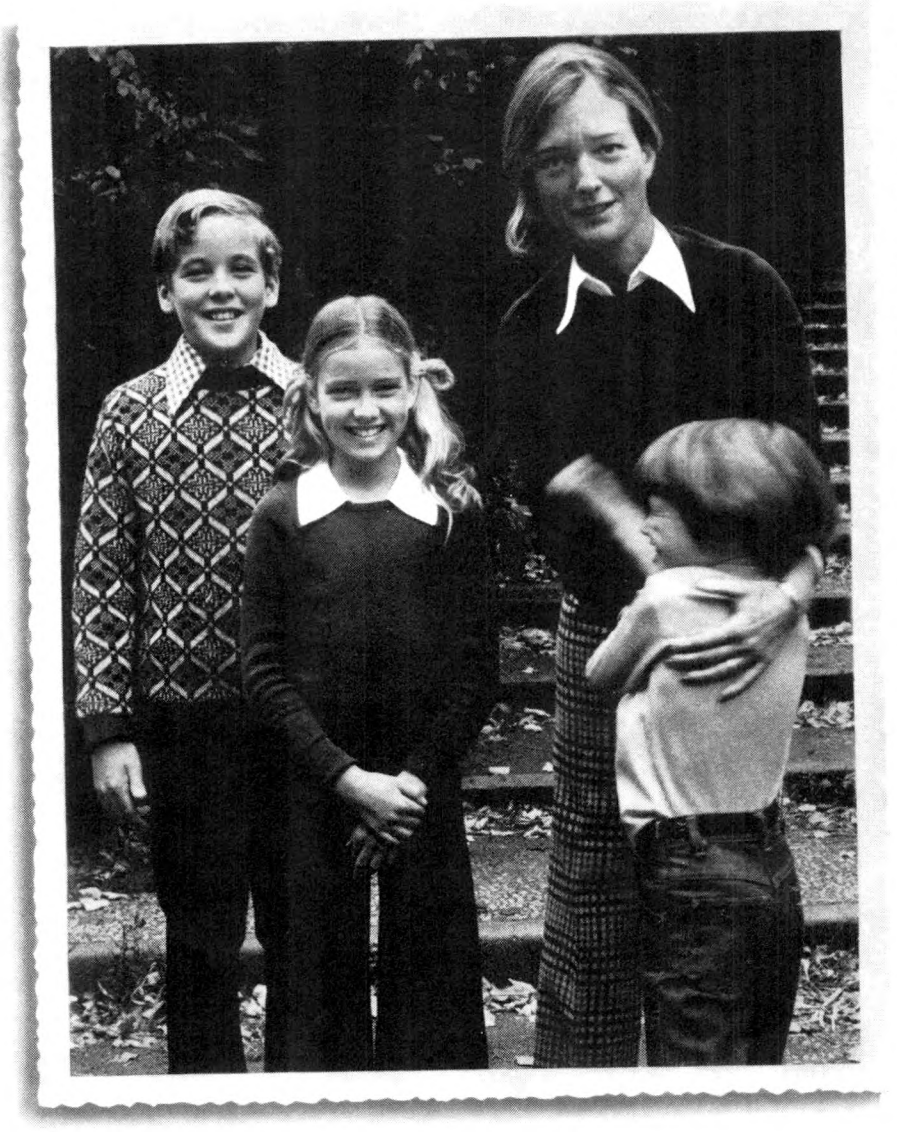
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IBD Case History #1

1971 ...a difficult child, a distraught mother Medical diagnosis: MBD



Robert Boynton,* second of five children, born October 7, 1963. Normal pregnancy and delivery.[1]

From the age of 3, Robert's mother found him "hard to handle," "wilder" than his brothers and sisters.[1]

At age 6, after an "extremely difficult" experience in kindergarten, Robert was referred to a pediatric neurologist. The examination and later psychological testing revealed a host of the neurologic "soft signs," plus an abnormal EEG.[1]

The diagnosis: average intelligence, but multiple signs of an underlying organic dysfunction.[1]

At age 7, Robert was placed in a special first-grade class called an "extended readiness program."[1]

Later that year, her child's continued problems at school and at home made Robert's mother "increasingly desperate" for help.

An MBD child on the road to maturity..

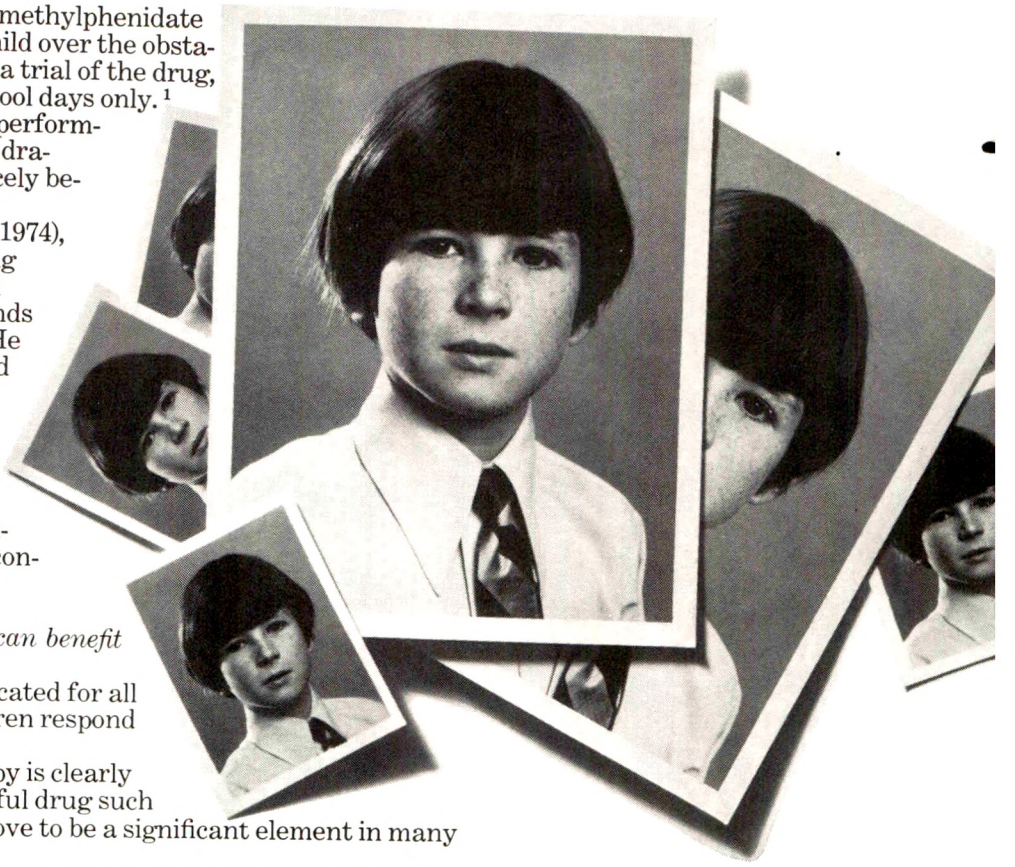
1974 ...a regular fourth-grader, accepted at home

In the opinion of the physician, methylphenidate (Ritalin) was called for to help the child over the obstacles of hyperactivity. So he initiated a trial of the drug, which was then implemented on school days only.[1]

The improvement in classroom performance and behavior was "prompt and dramatic." Robert's teacher could "scarcely believe" that he was the same child.[1]

For the past 4 years (as of April 1974), Robert has been maintained on 15 mg methylphenidate daily during school periods. During the summer he attends day camp and is not on medication. He is in a regular fourth-grade class, and behavioral problems at home have lessened. Robert's parents now find it much easier to accept their son.[1]

**Note:* In this presentation, clinical material has been used factually with the permission of the physician. However, identities have been concealed and names changed.



How other children with MBD can benefit from methylphenidate therapy

Of course, medication is not indicated for all MBD children; nor will all such children respond to drug therapy.

However, when pharmacotherapy is clearly indicated, the use of a widely successful drug such as Ritalin (methylphenidate) may prove to be a significant element in many complete remedial programs.

Over a decade of controlled studies has underlined the beneficial effects of Ritalin in producing improved behavior ratings,[2,3] better motor coordination,[2,4] and cognition and learning.[2,4] Indeed, it is currently the drug of choice in many MBD situations.[5]

And side effects with Ritalin have occurred less frequently than with other stimulant drugs.[4,6,7]

Dosage should be periodically interrupted in the presence of improved motor coordination and behavior. These interruptions often reveal that the child's behavior shows some "stabilization" even without chemotherapy, permitting a reduction in dosage and gradual elimination of drug therapy.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with medical diagnosis of MBD.



For brief prescribing information, please see following page.

Ritalin® (methylphenidate)

can help when medication is indicated

CIBA

Ritalin®
(methylphenidate)
Only when medication is indicated



Ritalin®hydrochloride Ⓒ
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with MBD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.

Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.

In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.

Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.

Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

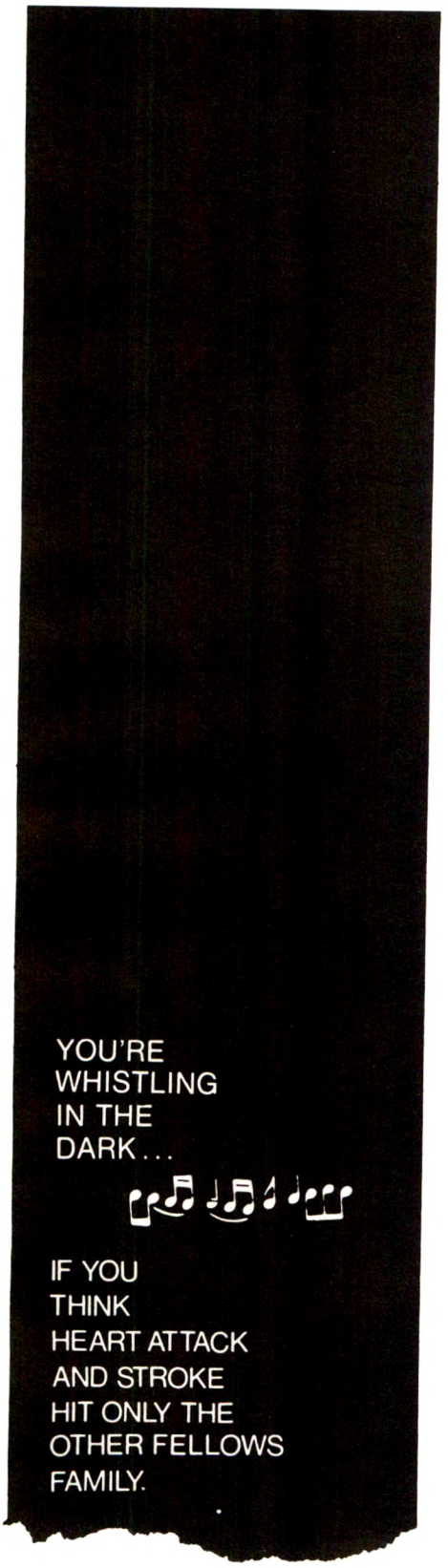
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4. Conners CK: *J Learning Disabil* **4**:476-483, 1971.
5. Charlton MH: *NY State J Med* **16**:2058-2060, 1972.
6. Paine RS: *Pediatr Clin North Am* **15**:779-800, 1968.
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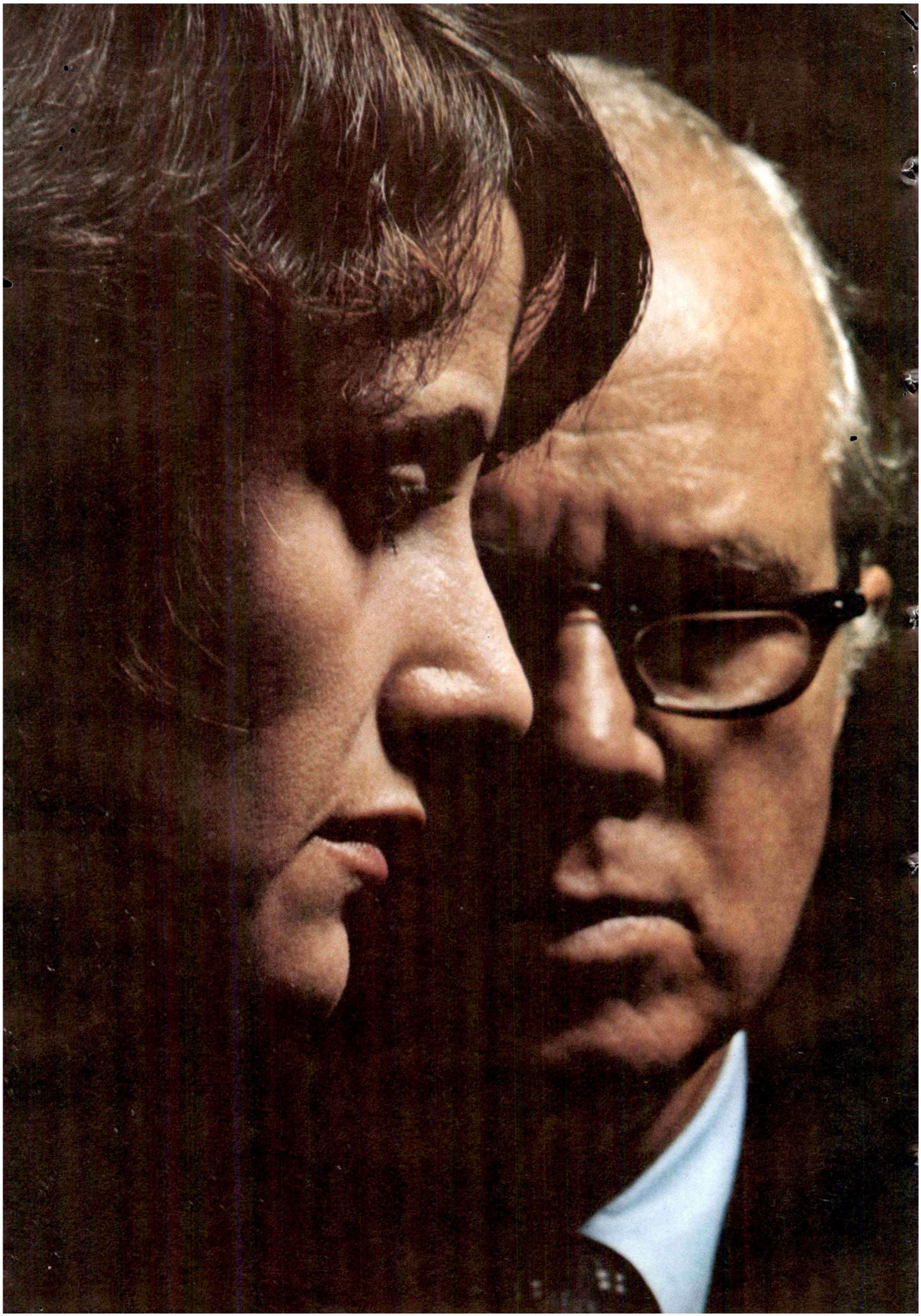
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The TRIAVIL® Potential in the management of moderate to severe anxiety with depression

When time and talk are not enough...
The therapist is the primary catalyst for change in the psychotherapeutic relationship. However, when patients suffer from moderate to severe anxiety with depression, there are situations when TRIAVIL can often be a useful adjunct.

...TRIAVIL may help
There are three important benefits you may expect when TRIAVIL is part of the treatment program: (1) When symptoms of moderate to severe anxiety or agitation with depression are relieved, the patient may become more accessible and cooperative. (2) As somatic manifestations are controlled, attention may be focused on underlying causative factors. (3) Symptomatic relief may enable the patient to function more effectively in his daily life while your work with the patient progresses.

Since it is simpler to remember to take one tablet rather than several (particularly in multiple daily doses), your patients on TRIAVIL will be more likely to take proper doses of the medication. And, of course, economy is an added factor in therapy with TRIAVIL.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

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For a brief summary of prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression

TRIAVIL® (containing perphenazine and amitriptyline HCl)
an antidepressant tranquilizer

when patients exhibit moderate to marked anxiety or agitation with depression

Triavil® 4-25

Each tablet contains
4 mg perphenazine and
25 mg amitriptyline HCl

a formulation particularly suited to psychiatric practice when higher doses are required.

Also Available:
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TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl

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TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of tricyclic antidepressant poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Cambridge State Hospital
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The Prince George Regional Hospital

is urgently requesting applications from a

1) Psychiatrist
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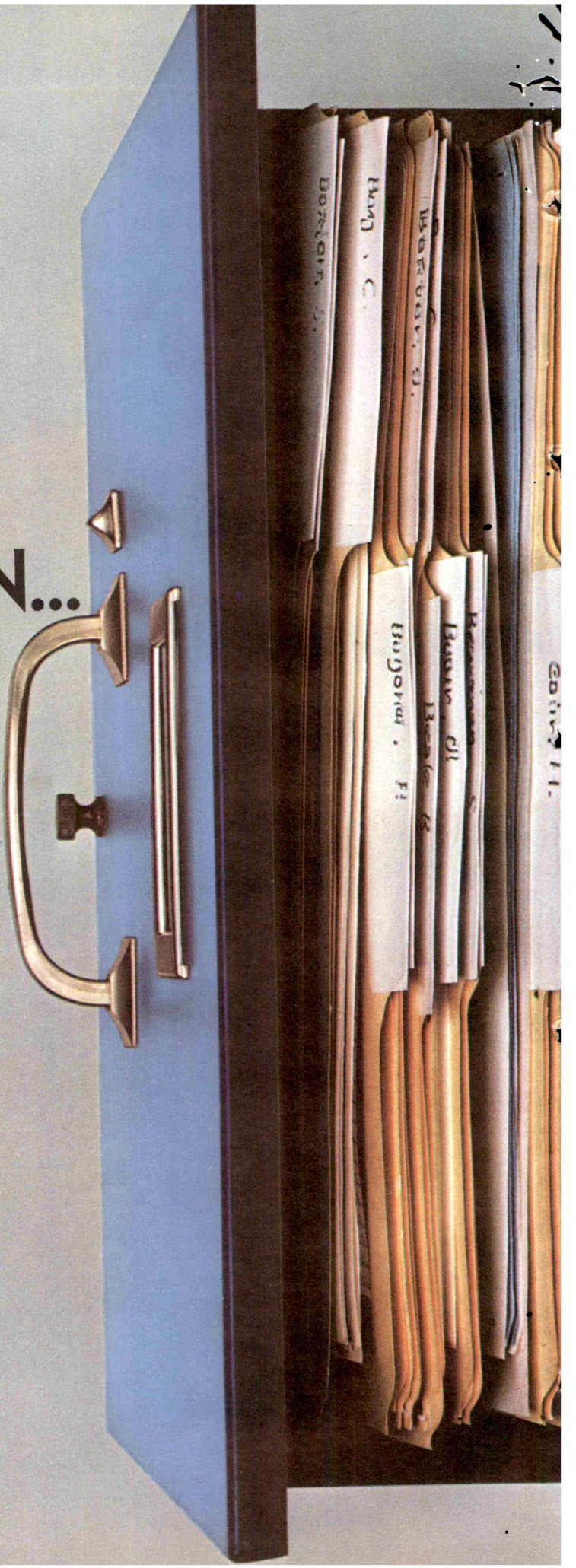
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Please direct enquiries to:
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Prince George Regional Hospital,
Prince George, B.C.
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The Dallas County Mental Health and Mental Retardation Center is in need of a Medical Coordinator for its comprehensive child and adolescent mental health program. The Center operates numerous community based programs and has excellent growth potential. License to practice in the State of Texas and Board eligibility in Child Psychiatry is required. Send vita or contact the Director of Personnel, 1200 Stemmons Tower North, 2710 Stemmons Freeway, Dallas, Texas 75207, telephone (214) 630-6100 for additional information. Excellent salary and fringes. An Equal Opportunity Employer.

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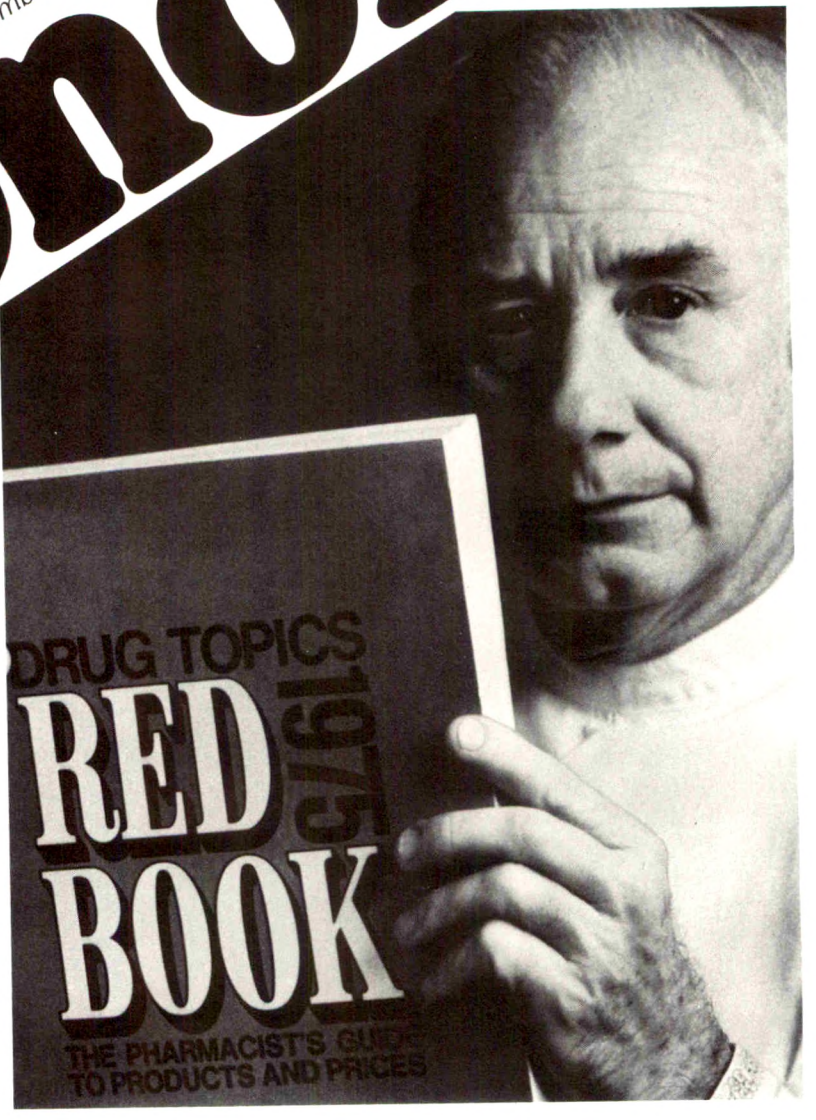
and three reasons for remembering it...

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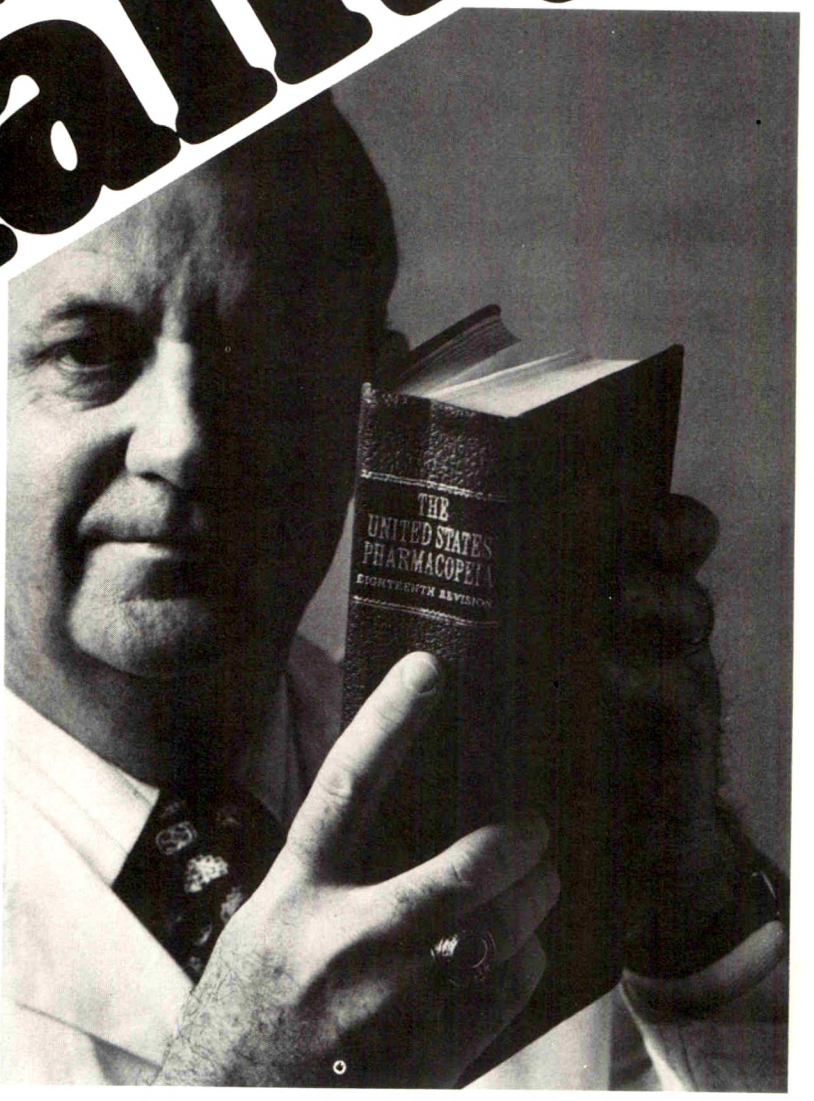
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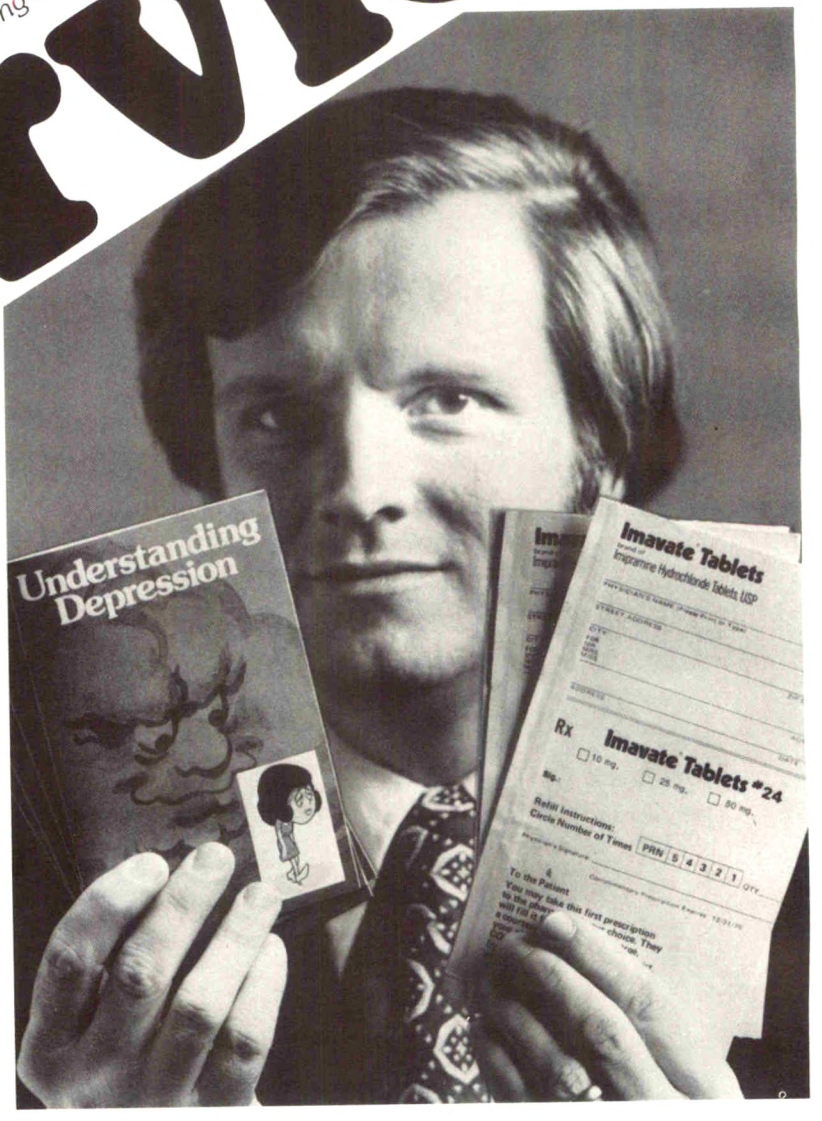
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rescribing Information:

ndications: For the relief of symptoms of depression. Endogenous depression is more likely to be alleviated than her depressive states.

Contraindications: The concomitant use of monoamine oxidase inhibiting compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations. The potentiation of adverse effects can be serious or even fatal. When it is desired to substitute imipramine hydrochloride, in patients receiving a monoamine oxidase inhibitor, as long an interval should elapse as the clinical situation will allow, with a minimum of 14 days. Initial dosage should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated during the acute recovery period after a myocardial infarction. Patients with a known hypersensitivity to this compound should not be given the drug. The possibility of cross-sensitivity to other dibenzazepine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of imipramine hydrochloride during pregnancy and lactation has not been established; therefore, this drug should be administered to women who are or who might become pregnant, or to nursing mothers, only when the potential benefits clearly outweigh possible hazards. There have been clinical reports of congenital malformation associated with the use of this drug, but a causal relationship has not been confirmed. Animal reproduction studies with imipramine HCl have yielded inconclusive results. Oral studies in rats and mice at doses up to 2½ times, and in rabbits at doses up to 25 times the maximum human dose, showed no clear evidence of teratogenic potential, but subcutaneous studies showed a teratogenic effect in rabbits and equivocal teratogenicity in mice at respective doses up to 5 and 6½ times the maximum human dose. Increased resorptions and stillbirths and decreased neonatal weights were seen in the oral as well as subcutaneous studies.

Extreme caution should be used when this drug is given to:

- patients with cardiovascular disease because of the possibility of conduction defects, arrhythmias, myocardial infarction, strokes and tachycardia;
- patients with increased intraocular pressure, history of urinary retention, or history of narrow-angle glaucoma because of the drug's anticholinergic properties;
- hyperthyroid patients or those on thyroid medication because of the possibility of cardiovascular toxicity;
- patients with a history of seizure disorder because this drug has been shown to lower the seizure threshold;
- patients receiving guanethidine or similar agents since imipramine hydrochloride may block the pharmacologic effects of these drugs.

Usage in Children: Pending evaluation of results from clinical trials in children, this drug is not recommended for use in patients under twelve years of age.

Since this drug may impair the mental and/or physical abilities required for the performance of tasks such as operation of an automobile or hazardous machinery, the patient should be cautioned accordingly.

Precautions: It should be kept in mind that the possibility of suicide in seriously depressed patients is inherent in the illness and may persist until significant remission occurs. Such patients should be carefully supervised during the early phase of treatment with imipramine hydrochloride and may require hospitalization. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine hydrochloride may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine hydrochloride should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine hydrochloride with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential, since there is limited clinical experience.

Adverse Reactions: Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine hydrochloride is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety,



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10 mg, 25 mg, 50 mg

restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever or sore throat during therapy: the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; bre largement and galactorrhea in the female; increase creased libido, impotence; testicular swelling; elev depression of blood sugar levels.

Other: Jaundice (simulating obstructive); alter function; weight gain or loss, perspiration; flushing; frequency; drowsiness, dizziness, weakness and headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative diction, abrupt cessation of treatment after pro therapy may produce nausea, headache and malai

Dosage and Administration: Lower dosages are mended for elderly patients and adolescents. Lower d are also recommended for outpatients as compared pitalized patients who will be under close supervisio age should be initiated at a low level and increased ally, noting carefully the clinical response and any e of intolerance. Following remission, maintenance n tion may be required for a longer period of time, at the dose that will maintain remission.

Oral: *Usual Adult Dose: Hospitalized patients*—I 100 mg/day in divided doses gradually increased mg/day as required. If no response after two weeks, in to 250-300 mg/day.

Outpatients—Initially, 75 mg/day increased t mg/day. Dosages over 200 mg/day are not recomme Maintenance, 50-150 mg/day.

Adolescent and geriatric patients—Initially, mg/day; it is generally not necessary to exceed 100 mg

Overdosage: *Symptoms:* These include drows stupor, tachycardia, ataxia, vomiting, cyanosis, hy sion, shock/coma, restlessness, agitation, hyperpyrex vere perspiration, hyperactive reflexes, muscle ri athetoid movements, convulsions, mydriasis. There n cardiac arrhythmia, EKG evidence of impaired condu and signs of congestive heart failure.

Treatment: There is no specific antidote. In emesis and gastric lavage are recommended. It m helpful to leave the tube in the stomach, with irrigatio continual aspiration of stomach contents, possibly pr ing more rapid elimination of the drug from the body room should be darkened, allowing only a minimal an of external stimulation, to reduce the tendency to cc sions.

1. Hyperirritability and convulsions have been cessfully treated with parenteral barbiturates in sever stances. However barbiturates should not be employ drugs that inhibit monoamine oxidase have also been t by the patient in overdosage or in recent therapy. Simi barbiturates may induce respiratory depression, particu in children. It is therefore advisable to have equipment a able for artificial ventilation and resuscitation when bar rates are employed. Paraldehyde has been used effect in some children to counteract muscular hypertonus convulsions without causing respiratory depression. Ar data indicate that an internuncial neuron blocker, suc methocarbamol, may be an effective treatment for cor sions and muscular hypertonus.

2. Shock (circulatory collapse) should be treated supportive measures such as intravenous fluids, oxy and corticosteroids.

3. Hyperpyrexia should be controlled by what means available, including ice packs, if necessary.

4. Signs of congestive heart failure have been satis torily treated by rapid digitalization.

5. If an extremely large overdose has been inges use of the artifical kidney may be helpful in eliminating drug from the body. However, due to low plasma leve the drug and a high rate of secretion in the stomach, it is that a more efficient technique is continuous gastric lava

How Supplied: Imavate Tablets, brand of Imipran Hydrochloride Tablets, USP (film-coated), 10 mg (white bottles of 100 (NDC 0031-5610); 25 mg (coral) in bot of 100 and 1000 (NDC 0031-5625); and 50 mg (fuchsia bottles of 100 and 1000 (NDC 0031-5650). June 19

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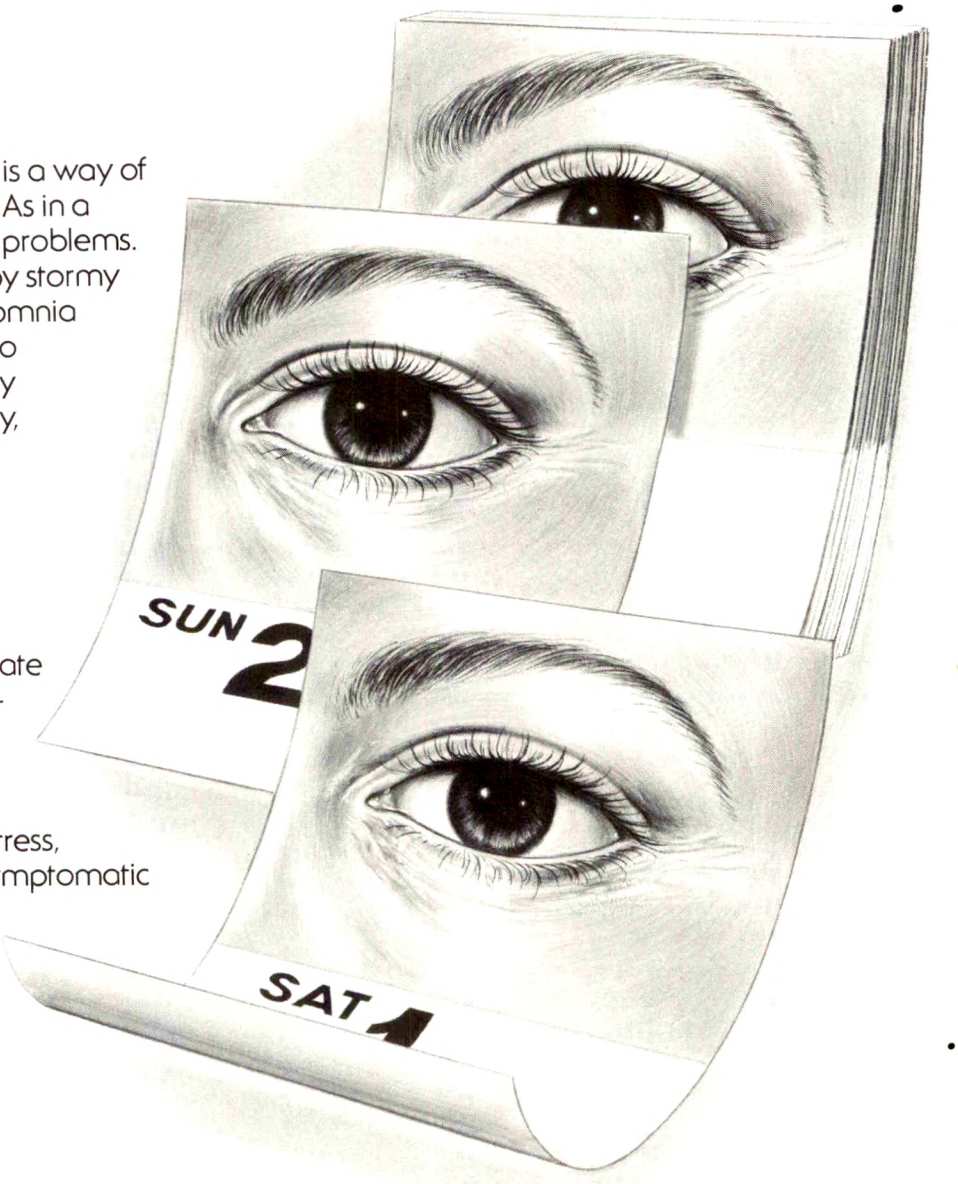
When did the insomnia begin and how does the patient react to it?

evolution of the insomnia

It has been said that insomnia is a way of striking out at another person. As in a marriage that has developed problems. Or a work situation troubled by stormy relations. More inclusively, insomnia is often a continuing reaction to events that are psychologically disturbing. With psychotherapy, you try to find them.

the patient's reaction

While some patients exaggerate their discomfort due to insomnia, others bear up remarkably well. When a patient with insomnia is overly concerned, or behaviorally in distress, you may want to give him symptomatic relief until psychotherapy can help improve sleep.



If a hypnotic is called for
NOLUDAR® 300
(methyprylon) C III

helps patients with insomnia slip gently into sleep

As an adjunct to psychotherapy, Noludar 300 can help relieve insomnia of varied etiology. Within 45 minutes, the patient is generally asleep.

offers a reliability that is assuring

You can rely on Noludar to promote an uninterrupted sleep of from 5 to 8 hours. The patient usually awakens with little or no "hang-over." While Noludar 300 is a Schedule III controlled medication, it is not a barbiturate or methaqualone.



Before prescribing, please consult Complete Product Information, a summary of which follows:

INDICATION: As a hypnotic for relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug. *Physical and Psychological Dependence:* Physical and psychological dependence have been reported infrequently. Withdrawal symptoms, when they occur, tend to resemble those associated with withdrawal of barbiturates and should be treated in a similar fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be limited without adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

Usage in Children: Not recommended in children under 3 months of age.

PRECAUTIONS: Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits. Observe usual precautions in hepatic or renal disorders. Perform periodic blood counts if used repeatedly or over prolonged periods.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few, isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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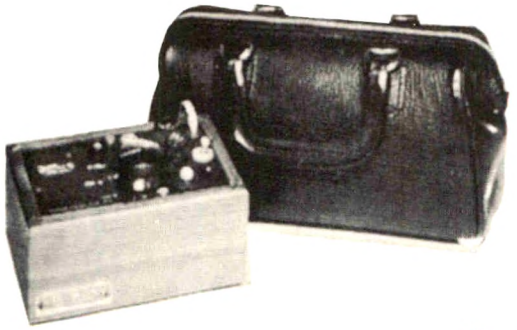
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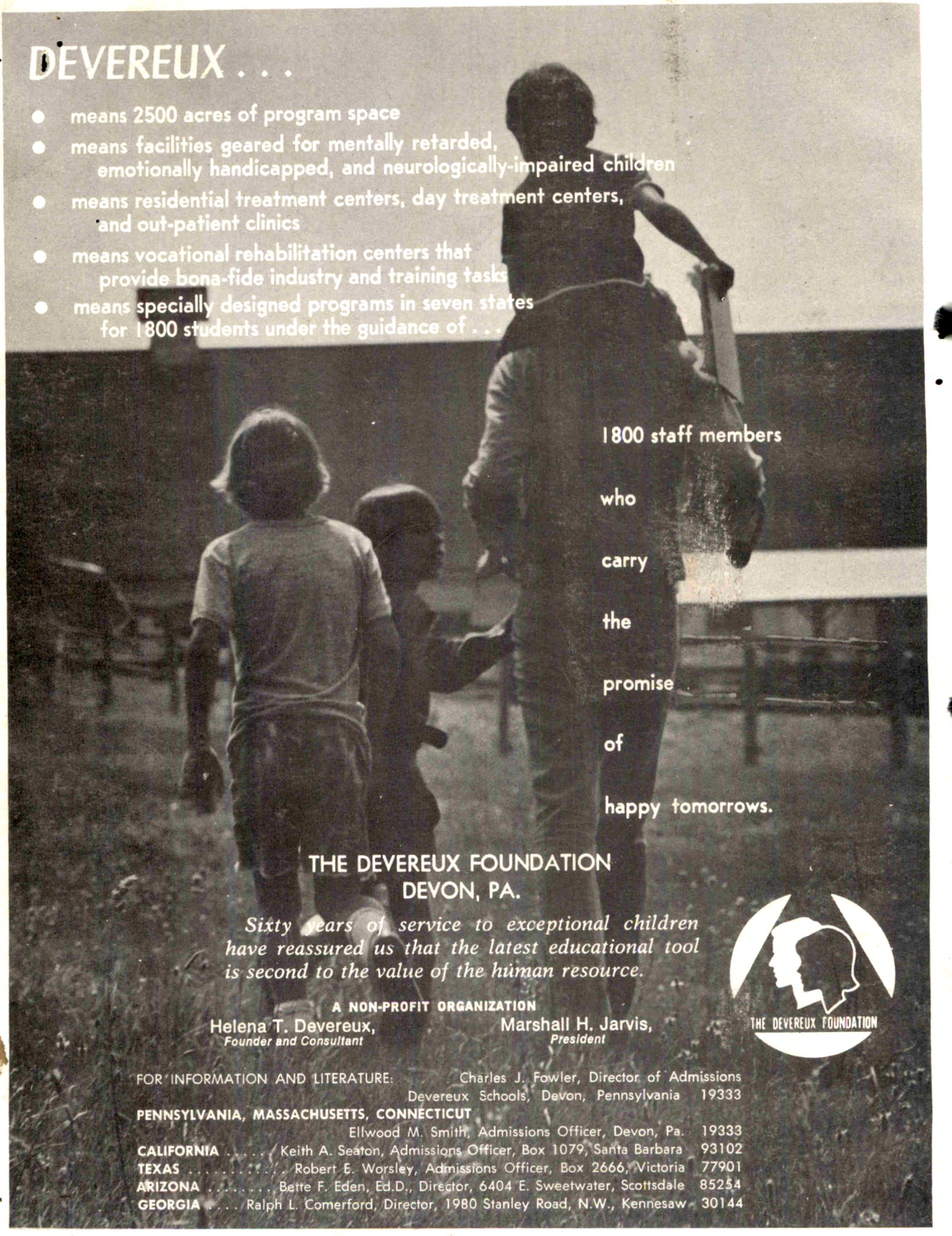
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